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**Developing the capacity to respond to
Child and Adolescent Mental Health
(CAMH) needs: Exploring how transferable
nursing skills are to parents whose children
have challenging behaviours**

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Thesis submitted in partial fulfilment of the requirements
of Northumbria University for
Degree of Doctor of Philosophy

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Abstract

This thesis focuses on child and adolescent mental health. Epidemiological studies show that in order to manage the high prevalence of Child and Adolescent Mental Health (CAMH) problems within the finite resources of CAMH services, it is necessary to develop innovative practice research and development. Research and literature in CAMH is dominated by the quantitative paradigm rather than participative and qualitative approaches. However, research indicates that although evidence based strategies, derived from this research perspective, such as manualised parenting programmes, can be effective for children with challenging behaviours, that the most vulnerable parents are the most difficult to engage and maintain within community parenting programmes.

This thesis takes a practitioner research perspective in order to work collaboratively with a small population of vulnerable parents, whose children have challenging behaviours that are interfering with the family's everyday life and impacting on the child's ability to meet their social, emotional and developmental goals. It builds upon a previous research project with nurses in a residential setting. The nursing project identified a specialist set of knowledge and skills, which were found to be useful in informing 24 hour care provision for children in a residential CAMH Unit and improving the behavioural outcomes for the children being looked after. The nurses' role overlaps with parents in the provision of 24 hour care, but the extent to which this nursing knowledge learnt in the previous study can be used by parents to maintain improvements in children's behaviour was not known. This thesis used a combination of qualitative methods within a participative action research approach and a critical theory perspective to engage in emancipatory research with parents as co-researchers. Action research starts from the premise that the solution to our problems are in our own hands and knowledge and understanding can only be developed through an exploration and learning from our everyday experiences. This thesis set out to learn:

- (1) Whether the nursing knowledge, derived from the nursing project, is transferable to parents in their community setting, and useful to parents when caring for their children with challenging behaviours in maintaining and improving behavioural outcomes.
- (2) Whether parents can refine and develop the nursing knowledge and so add to a cumulative body of practice knowledge related to the 24 hour care of children with challenging behaviours
- (3) Whether gaining access to this knowledge as participants within the research process can increase the potential capacity of parents to be able to respond to their children
- (4) Whether the knowledge and potential capacity of the wider system providers and policy makers can be increased through access to the parents' knowledge, expertise and experiences in caring for children with challenging behaviours.

In undertaking this research it is important to distinguish between the practice development and the research process. Action research is used to distinguish the two processes. The practice development incorporates an action research cycle which enables a learning process to occur in which new knowledge can be produced that can

be subsequently theorised. Theorisation is used to critique the oppressive care processes produced by the medical model and to theorise alternative practice processes that can be used to overcome the oppression inherent in the medical model and increase the effectiveness of CAMH services.

Twenty-five parents met the sampling criteria by engaging in at least one action research cycle. The action research cycles were used to explore extent to which the nursing knowledge and skills were transferable to parents in a community setting. Critical incidents were used to explore the parents' experiences of knowledge transfer. The findings illustrated that the transfer of the nursing knowledge to parents was useful, but not sufficient to increase the parents' capacity to respond to their child's needs because of a complex range of socio-political factors that differentially impacted on the parents' lives, compared to the nurses in the residential setting. This included isolation, guilt, housing and socioeconomic factors. In addition, the parents identified that they were subject to a range of oppressive forces that potentially reduced their capacity to respond to their children. Many of these tacit forces were found to be embedded in the medical discourse around CAMH practice and include a tendency to engage in the professional hegemony of knowledge, which legitimates the power of professionals to define the norms of behaviour in ways that can be oppressive towards and pathologising of vulnerable groups of children, who may not conform to a narrow construction of behavioural norms and the tacit idealisation and devaluation of carers. Together these can provide a rationale for blaming parents and for investing in services designed to improve parenting competencies whilst not having to address the wider socio-political determinants of child behaviour. The research findings indicate that challenging these oppressive assumptions within a supportive group setting, in which the parents actively participated in the research process, helped the parents to challenge and in some cases to transform their situation and that of their child.

In keeping with a participative action research, the findings from the collaborative research with the parents are synthesised into a practice framework, which represents the emerging action plan. A critical analysis of the opportunities and constraints for implementing this action plan is provided. The research demonstrates that engaging in participative research with clients whilst also engaged in practice is a complex and problematic process, which requires an innovative combination of methods but which can produce new and innovative ways of theorising practice processes and outcomes. Through the research process described in this thesis the oppressive nature of many well-intentioned aspects of CAMH practice are revealed and theorised. In taking this analysis forward practice processes and outcomes are theorised in the context of both the medical and social models of health. The research demonstrates how these two models can be integrated in practice and how the process of integration has the potential to enable the development of a cumulative and integrative body of emancipatory practice knowledge, which acknowledges and addresses the complexity, uncertainty and unpredictability of clients 24 hour experiences but at the same time maximises the total set of resources available to both support families and also to widen the capacity of professionals and service providers to develop insightful and non-oppressive solutions.

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Abbreviations used

CAMH	Child and Adolescent Mental Health
DBD/DBP	Disruptive Behaviour Disorder/Disruptive Behaviour Problems
ADHD	Attention Deficit Hyperactivity Disorder
ICD ¹⁰	International Classification Disorders (World Health Organisation)
DSM IV	Diagnostic Statistical Manual (American Psychiatric Association)
DoH	Department of Health
DfES	Department for Education and Social Services
ONS	Office National Statistics
NSF	National Service Framework (DoH and DfES) for Children, Young People and Maternity Services
RCT	Random Control Trial
Nursing PF	Practice Framework emerging from the nursing research upon which thesis builds
Revised PF	Practice Framework emerging from this thesis

Chapter 1 Introduction

This thesis makes a theoretical contribution to the development of practice knowledge both in terms of methodology and in terms of developing a model for the transferability of knowledge across the client/professional interface. It makes three main contributions:

1. The analysis of parental critical incidents and action learning undertaken in this thesis enables a theorisation of the effect on the life experiences of the children using Child and Adolescent Mental Health Services (CAMH) and their parents produced by the dominance of the medical model in determining the evidence base for practice and service provision in CAMH, the types of knowledge the medical model gives rise to and the types of knowledge it obscures and devalues. Although the critique of the medical model is not new in sociology (Turner 1995, Gabe et al 1994, Helman 2000) with theorists focusing on both physical illness (Earle and Letherby 2003, Freund et al 2003) and mental health (Gilligan 1982, Samson 1995), there is a dearth of this type of theorisation in relation to CAMH practice and services. The theorisation of the medical model in the context of CAMH services adds two further dimensions to the sociological literature. Firstly, theorisation of the medical model in CAMH services indicates how because of the increasingly narrow definitions of conformity which characterise our social institutions such as schools, child care and leisure centres, the medical model can legitimise the process in which the extreme ranges of behaviour in the normal population distribution curve of behaviour are constructed as non-conformist childhood

behaviours, by assessing them as abnormal and either medically or socially pathological. This can be illustrated with reference to temperament. Even though the extreme ranges of temperamental behaviours mainly fall within the normal population distribution range of childhood temperamental behaviours, these behaviours challenge the family and social context of the child's upbringing and therefore interfere with the family's everyday life, impacting on the child's ability to meet their social, emotional and developmental goals (Kazdin 1992, Offord 1996, Mental Health Foundation 1999). Universal Services are, therefore, required to help vulnerable families overcome the disadvantages that will be experienced by the child if the temperamental needs of these children are not acknowledged and responded to. This is discussed further in chapter eight.

Secondly, the thesis contributes to the sociological literature by demonstrating how the adoption of a medical approach as the main service response to CAMH problems, can create a causal model in which the child's main carer, their parent (usually mother), is implicitly and covertly blamed for the child's "condition" and seen as a major contributor to the pathology. Consequently treatment regimes focus on correcting parental behaviour rather than identifying and rectifying the wider socio-political risks, which may underpin CAMH problems. Through the methods of participatory action research and practitioner research used in this research, the thesis is able to produce additional evidence enabling a more in-depth theorisation of the double oppression of parents in CAMH as described above, which has not been

adequately explored previously in sociological or practice literature, related to CAMH.

The theoretical debates in medical sociology about the dominance of the medical model and its influence on individual life experience have been well rehearsed (Turner 1995, Gabe et al 1995, Helman 2000). The response in health sciences has been to undertake a critique of practice and service delivery models in order to improve effective provision. Thus for practice-based professions such as health and education, the theoretical and conceptual debate has moved on from abstract theoretical critique of practice and service provision to theorisation about effectiveness (Agyris 1993, Schon 1983, 1987, Fulop et al 2001, Miller and Crabtree 2000) and how this can be achieved in practice (Reed and Biott 1995, Muir Grey 1997, Centre for Reviews and Dissemination 2001, Rolfe 1998b, Popay et al 1998, Pawson et al 2004).

The early practice debate highlighted the limitations of traditional academic approaches in providing evidence for everyday practice, arguing academic evidence was too abstract and de-contextualised to be of much practical value in helping practitioners solve practice problems (Agyris et al 1985, Schon 1983, 1987). Later debates moved onto a discussion of how effectiveness is conceived, achieved and maintained in everyday practice contexts (Reed and Biott 1995; Rolfe 1998a, 1998b, 2003). From a quantitative perspective, increasing efforts are being made to develop a hierarchy of evidence, which classifies research results according to a consensus about the validity of the methods used. This approach usually assumes experimental methods are the most appropriate approach to researching effectiveness of practice

interventions and so these hierarchies are usually dominated by quantitative methods, while qualitative methods are considered less scientifically credible (Muir Gray 1997, Centre for Reviews and Dissemination 2001).

Cumulatively, this work has given rise to increasing recognition of the complexity of the practice situation and the oversimplification that occurs when practice is split up, for research purposes, into discrete strands or themes that are researched and theorised in isolation from each other. More recently the full complexity of research for practice has been mapped out by Pawson et al (2004) who state:

“The problem is one of complexity. The health interventions in question are not singular schemes or finite treatments but concern the design, implementation, management and regulation of entire services. These services have a multiplicity of goals, many of them relating to the fulfilment of long-term ambitions. By the same token, the evidence base for health service decision making is also gargantuan. In getting to grips with so many activities of so many actors, the seeker of evidence has to call on the entire repertoire of social science and health services research. A review may thus involve a dissection of experimental and quasi-experimental trials, process and developmental evaluations, ethnographic and action research, documentary and content analysis, surveys and opinion polls. Even this formidable list overlooks the pearls of wisdom to be found in the grey literature, including administrative records, annual reports, legislative materials, conceptual critique, personal testimony and so on” (Pawson et al 2004, p.iii).

It is to the health sciences literature and to debates about theorisation of effectiveness in practice that this thesis makes its main theoretical contribution.

2. The thesis contributes specifically to the practice knowledge base of Child and Adolescent Mental Health (CAMH) by theorising the process by which parents can be enabled to utilise professional knowledge in order to meet the 24 hour care needs of their children and the potential contribution to the knowledge base for 24 hour care that parents of children with CAMH problems could make arising from their situational context. It provides evidence of a theoretical link between increasing parental access and contribution to knowledge and the capacity of the services to respond to need using non-oppressive practices in the context of rising demand and finite resources.
3. It makes a theoretical contribution to the practice development literature by demonstrating how critical social theory can be used in practice settings to analyse the dynamic between patient and carer knowledge and professional knowledge and so develop a theoretical framework which provides practitioners with practical, everyday, practice responses to sociological critiques of practice derived from the dominance of the medical model in determining knowledge parameters. It therefore provides a practice response to sociological critiques of practice and to the specific evidence of oppression of CAMH users described in the results of this thesis. This response could only be produced through a theorisation of the practice situation as

experienced by the parents who took part in the study and an in-depth analysis of the experiences and problem solving potential of the research participants.

This thesis used a combination of qualitative methods within a participative action research approach and a critical theory perspective to engage in emancipatory research with parents as co-researchers. The thesis builds on the perspective of action research developed by Winter (2001) that recognises that action research starts from the premise that the solutions to our problems are in our own hands and knowledge and understanding can only be developed through an exploration and learning from our everyday experiences. Action research was first developed by Kurt Lewin as a “pioneering approach toward social research which combined generation of theory with changing the social research system through the researcher acting on or *in* [my italics] the social system” (Susman and Evered 1978 p. 586). Using this perspective, the integration of research with action is viewed as the strength of the method, creating the potential for learning and knowledge generation inherent within the study (Winter 2001). This thesis set out to learn:

- (1) Whether the nursing knowledge, derived from the nursing project, is transferable to parents in their community setting, and useful to parents when caring for their children with challenging behaviours in maintaining and improving behavioural outcomes.
- (2) Whether parents can refine and develop the nursing knowledge and so add to a cumulative body of practice knowledge related to the 24 hour care of children with challenging behaviours

- (3) Whether gaining access to this knowledge as participants within the research process can increase the potential capacity of parents to be able to respond to their children
- (4) Whether the knowledge and potential capacity of the wider system providers and policy makers can be increased through access to the parent's knowledge, expertise and experiences in caring for children with challenging behaviours.

However, in undertaking research using practitioner and participatory action research it is important to clarify the research process and in particular to distinguish the process of analysis. The iterative cycle which characterises action research is used to distinguish the research and analytic process in this thesis. The practice development introduced as part of the research process was incorporated in an action research cycle which enabled a learning process to occur that in turn produced new knowledge, which was subsequently theorised. The knowledge generated from the action cycle is used to identify and theorise the oppressive care processes experienced by participants in this research. Theorisation is used to understand how evidence-based care processes provided by well-educated and intentioned practitioners that are designed to improve outcomes for these service users may actually have the opposite effect and lead instead to oppression and further marginalisation. Subsequent action research cycles were undertaken and the knowledge generated used to theorise alternative practice processes that can be used to overcome the oppression inherent in the current system of care and increase the effectiveness of CAMH services. This is covered in more depth in Chapter Four. The action research cycle is used to distinguish between practice outcomes and research outcomes and this is illustrated in figures 2 (opp. page 188) and 3 (opp. page 193) in Chapter Four.

Theoretical Context

The literature is covered in depth in the literature chapter, but will be summarised in this introductory chapter in order to signpost the structure of the thesis. There is significant national and international evidence which identifies the high and increasing prevalence of CAMH problems in western society (Offord et al 1998; Office National Statistics 2000). This evidence highlights the fact that only about 1 in 6 children who need CAMH support are receiving it (Offord et al 1989, Offord et al 1998; Office National Statistics 2000). Resources to meet this problem are limited, evidenced by increasing waiting lists for CAMH services reflecting increasing demand from the population for help with these problems. There is evidence that the burden of illness i.e. the distress to the child, the family and the community and the fiscal cost is significant in this group (Offord et al 1998). This is particularly the case if the cost of law enforcement agencies such as the police, prison service and court service are included in the calculations (Knapp et al 1999) although hard (statistical) evidence linking health care to crime reduction among these children has yet to be established within the evidence base for health sciences. The parents who participated in this research were very concerned about this prospect for their children, as the data given in the findings section of the thesis indicates, and it was one of the prime reasons why they sought help.

Although there is an extensive academic literature base in CAMH, designed specifically to look at the above issues (Offord et al 1998, Henggeler et al 1995; Hoagwood et al 2001) the parents' perspectives on how this substantial knowledge base actually affects them, how it could be used by them or how they could actively contribute to this cumulative knowledge base, has barely been explored in CAMH

literature or practice. This is in contrast to UK National policies such as the National Service Framework for Children, Young people and Maternity services (DoH and DfES 2004) where Standard 9 specifically focuses on CAMH and emphasises that the perspective of carers and children must be explored and incorporated into care plans. While it is fully recognised that in addressing this inherent contradiction in the delivery of CAMH services, this thesis touches on a wide range of sociological debates about the nature of health and illness in society, the definition and provision of care, gender, professional power and the role of professionals, the thesis adopts a health sciences perspective which is primarily concerned with the effectiveness and efficiency of health service delivery (Fulop et al. 2001; www.sdo.lshtm.ac.uk).

Much of the evidence base for CAMH practice is derived from traditional experimental research using Randomised Controlled Trials that are seen as the “gold standard” in health services research in the developed world (Rolfe 1998b, Rolfe 2000, Muir Gray 1997). This source of evidence is, however, increasingly and incrementally being challenged and in CAMH a number of academics, in particular Henggeler et al (1995) and Hoagwood et al (2001), have identified that the real issue for service delivery in CAMH is how to achieve effectiveness in the 24 hour care of children rather than efficacy in controlled trials. Given the identification of this problem in mainstream CAMH literature, the thesis is specifically located around nursing practitioner research because nurses are characterised as providing and facilitating 24 hour care. This thesis builds upon a previous study (Croom 1996, Croom et al 2000) which employed participative action research with CAMH nurses in an in-patient setting to identify the knowledge and skills used by these nurses to

provide 24 hour care to children with CAMH problems. This study is discussed in more detail in Chapter 5.

The thesis problematises the difficulties of achieving a cumulative knowledge base related to 24 hour CAMH care in the changing world of practice and the diverse care context/lived experiences of a range of children and families. Most health science research is based on the premise that the wise use of scarce resources and the ethical responsibility to avoid exploiting research participants requires that health research will improve the well-being of people or will increase knowledge (Emmanuel et al 2000). Participatory research has its roots in work with oppressed peoples, and is therefore, specifically designed to access hard to reach and marginalized communities (Khanlou and Peter 2005). There is an established body of evidence in CAMH which indicates that the most marginalised and hard to reach sections of the community experience the most severe CAMH problems (Offord 1996, Webster-Stratton 1998, Mental Health Foundation 1999). Current evidence suggests that this section of the population is least likely to access services and most likely to drop out of CAMH programmes (Firestone and Witt 1982, Forehand et al 1983, Pugh and Smith 1996). Participatory action research makes improving the well-being of participants a condition of the research process rather than a gift they make to society (Khanlou and Peter 2005) and recognises that excluded groups are the sections of society least likely to benefit from research investment. Kemmis (2001) argues that participatory action research is emancipatory and aims to help people recover, and release themselves, from the constraints of irrational, unproductive and unjust social structures that limit their self-development and self-determination. Gaventa and Cornwall (2001) argue

that the knowledge gained from participatory action research is focused upon action, not understanding alone.

The choice of participatory action research in this thesis builds on a body of literature which testifies to the appropriateness of this method when researching hard to reach or marginalised communities (Khanlou and Peter 2005). Despite the substantive CAMH research base described above and in more detail in Chapter 2, concerns are consistently raised in the CAMH literature about the difficulties of recruiting the most marginalised and deprived families both to services and to research (Offord 1996, Webster-Stratton 1998, Mental Health Foundation 1999). A failure to recruit from the most deprived social groups further isolates and marginalises these communities from contributing to the evidence base for service delivery and therefore perpetuates their exclusion from mainstream services. In the light of this evidence, it was considered important in designing this research to target those communities most likely to experience exclusion.

Consequently, the thesis presented here is based on the premise that there is an ethical requirement to maximise all available publicly funded resources in ways which are client centred i.e. useful and relevant to the lived experiences of all clients in a situation characterised by high need and demand for services and finite resources to meet these needs and that research into practice processes is required to discover how this can be achieved within contemporary practice situations.

The literature in participatory action research recognises that in researching marginalised communities the ethical dimension of participatory action research is of

central importance in developing the design of the research as it is recognised that a failure to address this aspect of study design will result in lower recruitment and a loss of data from marginalised groups increasing their social exclusion (Khanlou and Peter 2005).

In evaluating this research it is important to recognise that it is unlikely that the voices of the mothers, who participated in this research, would have been heard using more traditional qualitative methods. A particular strength of using participatory action research in a clinical setting, as described in this thesis, lies in expanding the evidence base for practice by giving voice to the lived experience of a marginalised, stigmatised and isolated group of women with high levels of need. Academic concerns about separating the research process from the practice development or intervention process in order to reduce data contamination and clarify research outcomes independently from the intervention, have their origins in positivist approaches to research concerned with linear processes, causality and non-contamination of data (Lewin 1948, Habermas 1984). In his critique of contemporary social science Habermas (1984) focuses attention on how our knowledge is constituted in practice:

“The social scientist cannot ‘use’ this language ‘found’ in the object domain as a neutral instrument. He cannot ‘enter into’ this language without having resource to the pretheoretical knowledge of a member of the lifeworld – indeed of his own – which he has intuitively mastered as a layman and now brings unanalysed into every process of achieving understanding” (Habermas 1984, p. 68).

Here Habermas is alerting us to the importance of paying attention to knowledge-constitutive interests, to addressing questions about how knowledge is constituted in practice and in research and to who constitutes and therefore has power over the production of knowledge. He is concerned to highlight the ontological debates that imbue scientific methods but often go unrecognised and taken for granted by researchers.

Academic concerns about the separation of the research process from the practice development process or practice intervention, are not just about research design. Recent developments in the analysis of qualitative data from a critical perspective recognise the difficulties researchers using qualitative methods face when theorising data from marginalized groups. Habermas (1984) has highlighted the importance of opening up the process of developing inter-subjective meaning and understanding.

“Habermas’ theory takes as its central value intersubjective agreement - rational, negotiated assent among autonomous, responsible individuals” (Grady and Wells 1985, p. 30). Habermas thus highlights the processes implicit in discourse in social research and the formation of knowledge and understanding that arises through the discourse between research participants. This generates new understandings by creating debate focused on the subjective experiences of participants in order to explore and articulate the inter-subjective meanings which mediate communication between the subjective worlds of the different participants.

Habermas makes an important distinction between discourse about society which addresses questions of truth, and discourse that addresses social norms [*for example,*

those discussed in this thesis- my italics]. Such discourse, which we may call social hermeneutics or, following Habermas, practical discourse, seeks to grasp its object of study precisely as part of a humanly formed, subjectivity-disclosing system. It is this distinction that is obscured by the handbook generalization about the facts of the case: we make the facts as much as we find them. The empirical sciences seek to establish technical control over their objects; hermeneutics seeks to open its objects to comprehension as forms of intersubjective communication” (Grady and Wells 1985, p. 35).

The implications of the position developed by Habermas (1984) is that any attempt to impose theorisation or generalisation onto a research process at the expense of the process of intersubjectivity that informed the research itself, is fundamentally flawed as it privileges the power position and autonomy of the researcher over that of other participants. This inevitably invalidates the research process as it denies the importance to social transformation of developing knowledge based on intersubjective or shared understandings. Using this perspective it is important therefore not to theorise or generalise beyond the level of intersubjectivity achieved in the research.

Habermas’ position accords with the values adopted in this research and the choice of critical social theory as the methodology used in the research. The analysis, therefore, focuses on developing shared understanding and generating inter-subjective meaning through a discourse between the research participants acting as autonomous adults and the professional literature and knowledge base which informed the research process. It is within this context that theorisation is undertaken in this research.

The findings in the research about the oppression experienced by the women who participated and the limitations of knowledge generated using a medical model and experimental research designs, could in some senses be seen as self-evident. They could be criticised as reinforcing a self-validating world in which the methodological perspective adopted determines the findings or research outcomes. In one sense this can be viewed as a weakness of this approach, but only if one adheres to an understanding of social research as producing an objective reality independent of those who participate. Both action research (Lewin 1948) and critical social theory (Fontana 2004) dispute this position.

The sociology of knowledge has been the subject of extended debate in sociology (Simmonds 1978, Abercrombie 1980, Worsley 1997, Irwin 2001). This debate centres on the interaction between ontology and methodology in social research and recognises that the findings from any social science research are ultimately a product of the methods used. It follows that validity relies on the use of methods appropriate to the research problem and the analysis of data in keeping with the chosen methodological perspective. From the perspective of the sociology of knowledge, the findings from this research actually validate the methods used. To have failed to find oppression and identify the limitations of the medical model would be cause for concern about the validity of the findings given the methods used and the population sampled. This does not however, negate the findings of the research as self-evident, obvious or deterministic. This is the first time this type of analysis has been undertaken in CAMH. The research provides empirical evidence of the causes of exclusion embedded in current practice processes and of considerable concern in the CAMH research and service delivery literature. This evidence could not be obtained

using more experimental approaches to research which are constrained by adopting the ontological position of the medical model. Neither could this evidence be obtained using more traditional interview based qualitative based methods, as it is highly unlikely that these women would have been volunteered to take part in this type of research.

The empirical evidence produced in this thesis enables clinical understanding to move from theoretical speculation and academic debate, to theoretical and evidenced-based practice processes designed to overcome oppression and challenge the medical construction of knowledge and therefore, increase service effectiveness; it is this which constitutes the original contribution to knowledge and theorisation in this thesis.

Theoretical Focus

The theoretical focus for this thesis centres on the practice knowledge required to provide 24 hour support for children with recognised CAMH problems, characterised by challenging behaviours, which cause significant distress to the everyday lives of the children and families and negatively impact on the child's developmental potential. The theoretical perspective is specifically located around nursing practitioner research because nurses are characterised as providing and facilitating 24 hour care in health service settings. It builds on an earlier published practitioner research project with nurses in a CAMH residential unit, discussed in Chapter 5, Chapter 5 describes findings from the previous study with nurses which demonstrated how difficult it was for nurse practitioners in 24 hour caring situations to articulate all of their tacit experiential skills and access their tacit expertise. Although there was a

plethora of CAMH literature, there was a paucity of literature on 24 hour care of these children, and this practice theory gap meant that the nurses found it difficult to develop, their own practice theories related to 24 hour care. A finding emerging from this nursing research was that nurses felt relatively disempowered because they felt that nursing practice theory was not represented by and did not contribute to the dominant literature represented by psychology and psychiatry. In the previous study, nurses used critical incidents to engage in reflective action cycles related to their practice problem, which they identified as how to care for children with disruptive behaviours who exhibited a poor sense of control. Through the reflective action cycle, they analysed the critical incidents to explore their practice knowledge and skills. This was followed with the research action, which constituted access to a diverse range of literature generated through a concept analysis (Walker and Avant 1988) of control, followed by an exploration of how their practice understanding was improved by interrogating the incident in the light of the knowledge produced using the concept analysis of control. All of the participating nurses found that access to this diverse range of literature helped them to interrogate their practice in a way, which enabled them to articulate their previously tacit and hidden practice experience.

The nurses thus engaged in participatory action research to inductively analyse their own practice experiences using a deductive set of knowledge derived from the published literature. Key findings were that the nurses understood the problem better, could recognise the quality of the solutions that they had been providing in their nursing care, could implement new solutions and could evaluate these in the light of practice. They could then build upon their analysis to refine and develop a set of nursing knowledge and skills that were useful to them in providing 24 hour care for

these children with very challenging behaviours. Through engaging in this practitioner research, the nurses gradually produced a practice framework that was grounded in the research and is illustrated in Appendix 1. Analysis of the nursing data also illustrated that a common emerging theme was how empowered the nurses felt as a result of being able to recognise, explicate and disseminate their previously hidden expertise. Chapter 5 describes how the nursing framework and findings were converted into a set of propositions, which could be tested out through action research with parents in this thesis in order to discover if the research process used with nurses could be repeated with parents, who offer 24 hour care in the community and whether the cumulative process of knowledge generation could be continued with another sample in a different context.

In order to achieve this, a number of the strategies used in the previous nursing research project (Croom et al 2000), discussed in Chapter 5 of this thesis, were employed with the parents in this thesis:

- (1) The parents were given access to the practice framework of nursing knowledge and access to other literature, known to the facilitators, which might be useful to parents in helping them solve problems of everyday care in their lived experiences. In other words they were given access to a new language and set of concepts in order to identify whether this helped them make more sense of their child's behaviour, whether this enabled them to manage their child more effectively in their terms and whether it helped them to articulate their own taken for granted knowledge.

In retrospect it is possible to recognise that this process of opening up access to new languages and concepts through accessing relevant professional literature is central to the concept of hermeneutics in social science. Giddens (1982) in developing the concept of the double hermeneutic recognises that the relationship between social science concepts and lay or everyday concepts is two way, social actors can re-appropriate social science concepts into everyday language and life. The way in which they do this and the new knowledge and shared meanings it produces becomes the focus for data collection and analysis.

- (2) Data collection captured the debates of the parents with each other and with the group facilitators as they tried to make sense of this knowledge in the context of their own problems. In the thesis this is described as the inductive analysis of a deductive knowledge base. The analysis was designed to explore whether the knowledge provided was useful and meaningful to the parents and if it was, which aspects were useful and why and if it wasn't, which aspects were not useful and why.
- (3) The principles of participatory action research were employed in order to work collaboratively with the parents to achieve a practice change. Participatory action research principles and action science principles were applied to test the strengths and limitations of the nursing practice framework in the parental context.

In order to undertake this research the thesis used a practitioner research perspective (Rolfe 1998a and Role 1998b; Richardson et al 2004a and 2004b; Procter 1995) which is characterised by:

- (1) An explicit value of 'improving practice'. This necessarily incorporates a debate about what is meant by improvement and from whose perspective and therefore provides the requirement to make underpinning value judgements explicit. It could be argued that although the concept of improving practice is implicit in the vast majority of health sciences research including the randomised control trial methodology (Emanuel et al 2000), it is rarely theorised and a consensus is assumed among leading health sciences academics that improvement focuses almost exclusively on reducing mortality and morbidity. Hence the difficulties health sciences have in undertaking research into the effectiveness of service delivery where the outcome may not be measurable in these terms and maybe imbued with cultural values.
- (2) The thesis acknowledges the changing and frequently chaotic nature of the practice world/lived experiences of participants and how practice research is continually striving to develop methodologies that can undertake research which is both a part of this practice world and at the same time methodologically sound (Rolfe 1998a, Pawson et al 2004).
- (3) It recognises that there is a need to develop a cumulative knowledge base for practice which can be used by practitioners to help them make sense of their

world and more importantly to improve the service they offer to clients (Rolfe 1998a, Pawson et al. 2004).

However, in adopting these methods it was recognised that the bulk of practitioner research in nursing relates to developing practice with fellow nurses (Bryar 2003, McCormack 2003, Meyer 2003). In taking this research forward the additional tensions of working with parents as opposed to nurses had to be addressed. As discussed earlier the sociological literature had alerted me to the importance of addressing the ascribed power (of referral, access to additional resources and role in child protection) inherent within the health professionals' role generally and therefore, in the role of a specialist CAMH practitioner who was simultaneously engaging in research while providing a service for the parents. From the parents perspective this could be interpreted as conducting surveillance as a researcher while simultaneously acting as an agent of the state. The relatively small amount of action research undertaken with active clients, means that this particular problem has not been fully addressed in the methodological literature or in the practice literature related to CAMH.

The thesis, therefore, builds on the work of medical sociologists and explicitly recognises the practice implications of the critical theoretical discourse on professional power produced in sociology (Turner 1995, Gabe et al 1994). It does not, therefore aim to make a theoretical contribution to the sociological literature, rather it produces a theoretical understanding of how practitioners can use this comprehensive body of sociological literature to inform practice and improve the effectiveness of services for marginalized and high risk client groups.

Deriving from the sociological literature, a central value employed in this thesis is that the aim is to produce emancipatory practice knowledge i.e. knowledge, which acknowledges the inherent oppression and ambiguities, which can serve to maintain the hegemony of powerful groups such as professionals at the expense of the clients they serve (Turner 1995, Gabe et al 1994). This value is espoused by critical theorists such as Freire (1985, 1993, 1994, 1998) and Fontana (2004).

The issue of professional power (Turner 1995) is therefore, central to the thesis, not as a theoretical issue, but as a practical lived problem that had to be addressed within the methodological approach taken by the research. This problem was addressed through the application of the principles of critical social theory (Fontana 2004). These principles were found to be applicable as they explicitly incorporated the notion of practice change (a defining feature of action research), within an emancipatory framework which addressed the power differential by getting both the researcher and the participants to focus on 'what could be' rather than what is' (Thomas 1993) and by identifying the tacit assumptions and beliefs of the participants and then challenging any tacit oppression underpinning these assumptions.

Critical social theory was thus used to develop emancipatory practice knowledge i.e. knowledge, which is emancipatory in the practice situation for those participating in the research. Emancipatory knowledge can be described as 'that which attempts to reconcile and transcend the opposition between technical and practical knowledge. Emancipatory knowledge helps us to understand how social relationships are distorted and manipulated by relations of power and privilege. It also aims at creating the

conditions under which irrationality, domination and oppression can be overcome and transformed through deliberative collective action' (McLaren 1989, p. 170). Thus, in this thesis, the parents were explicitly supported as a group to identify, interrogate and challenge any potential tacit assumptions, at an individual, professional and societal level which could possibly act to oppress them.

There are a number of unique outcomes arising from this thesis, which can be used to generate further insight, knowledge and theorisation and thus conform to the practitioner research perspective of generating a platform for further knowledge in a continuous iterative process:

- (1) The thesis describes and critically theorises a combination of methods which can be used to engage in emancipatory practitioner research with clients whilst simultaneously offering them a service
- (2) It provides a detailed analysis to illustrate how access to the wider professional CAMH knowledge base can be useful to parents and in some cases crucial to developing insight into their child's behaviour. However, in the case of this group of parents, this extensive knowledge, which is well known to the many professionals with whom these parents were coming into contact, had not been shared with them. Through an analysis of the parental oppression produced by application of the medical model in determining the life experiences of parents and children using CAMH services the thesis theorises why parents were not given access to publicly available information which improved their competence and confidence.
- (3) The thesis also provides a detailed analysis to circumscribe the transferability of knowledge derived from the nursing practice framework and to demonstrate

that access to this knowledge is useful, but not sufficient. It provides a detailed analysis of the socio-political factors which limit the transferability of nursing knowledge in CAMH to the parental context. In developing the theorisation of the impact of the medical model on the life experiences of parents and children using CAMH services the thesis demonstrates how the oppression produced by the medical model can reduce the effectiveness of CAMH services by failing to address the wider socio-political determinants which contributed to the pathologising of childhood behaviours. Many of these factors derive from the relative powerlessness of the parents when compared with the professionals and the parents reduced access to resources when compared with professionals. These factors can account for the difficulties parents experience in maintaining the improvements in behavioural outcomes achieved with these children in residential settings.

- (4) It provides a detailed analysis of how parents' experiences can contribute to and develop the insight and knowledge base of professionals working in CAMH.
- (5) The thesis identifies a particular set of risk and protective factors derived primarily from the traditional CAMH literature and modified by the parents experiences, described in this thesis. These were found to be useful with this set of parents, in helping to understand and respond to the individual profile of needs and strengths. These findings were developed into a practice framework (Appendix 2) which is currently being used by health and social care professionals as an action plan to respond to the needs of these children and to identify the types of resources that parents require to enable them to support their children, rather than the services they are currently allocated. This

practice framework is tentative and contingent and can be developed by other CAMH practitioners using the methods described here, to adapt the framework to their needs and circumstances.

In addressing the problem of the tentative and contingent nature of practice knowledge this thesis theoretically develops the concept of the iterative process which characterises action research (Meyer 2000 and 2001) to produce knowledge platforms (or practice frameworks) which are substantive at the time of production but because they are contextually bound are not definitive. This is demonstrated in the thesis through the production of a knowledge platform (Appendix 1), which was produced by nurses and contributed to the knowledge base for practice for nurses in the previous study, upon which the thesis builds. This is then further developed (by an extension of the iterative process) through research with parents in this thesis, which thus attempts to develop the nursing knowledge platform (Croom 1996; Croom et al 2001) or practice framework (Appendix 1) to a more sophisticated and inclusive level with parents (Appendix 2). It is emphasised throughout the thesis that both the nursing practice framework (Appendix 1 and discussed in depth in Chapter 5) and the practice framework derived from the work with parents in this thesis (Appendix 2 and discussed in Chapter 8) are limited by the methods used, the experiences and situational context of the participants, and the literature used.

The thesis therefore, makes a theoretical contribution to practice development literature through conceptualising practice frameworks produced from rigorous qualitative research. These frameworks are never-the-less open to further refinement in future research to accommodate situations and contexts that differ in significant

ways from the original settings (ie in this case education or social work practice), but which have enough commonalities (ie. in this case are concerned with the mental health and well being of children) to be able to build on the original research findings rather than start from scratch.

Practitioner research recognises the tentative and contingent nature of knowledge in practice settings and consequently does not claim to produce substantive or definitive knowledge, but works instead within a paradigm that recognises that practice knowledge is contextually bound and inevitably limited in terms of generalisation (Procter 1995; Rolfe 1998a, 1998b; Rolfe et al 2001). The iterative process developed in this thesis was designed so that other practitioners could use the methods described in the thesis to develop and adapt the practice framework to their local situational context, as the theoretical and methodological basis for this framework are made transparent.

This approach to practice knowledge development using a diverse range of sources and combination of methods thus makes an original contribution to the theoretical debates about knowledge generation for practice.

Structure and summary of chapters

As a final part of this introductory chapter, a summary of the rest of the thesis chapters will now be given to signpost the rest of the thesis.

Chapter two, the literature chapter, provides detailed discussion of the literature and evidence base on parenting groups in CAMH. The CAMH literature describes how to run these groups collaboratively and in a non-didactic way (Cunningham et al 1995 and 1998; Webster- Stratton 1998) but does not problematise the inequity in power between the professional group facilitators and the parent participants. Furthermore, the traditional parenting research (Cunningham 1995, Webster Stratton 1998) tends to use a manualised approach to disseminate the methods used and this approach does not address how parents can directly refine and contribute to the manual or the wider field of practice knowledge. This creates a tension in the use of the non-didactic approach advocated by CAMH parenting literature, which is not identified in the CAMH literature.

Dominated by the narrative of the medical model, research into parenting groups in CAMH literature thus tends to ask the question - how replicable and generalisable is the standardised, manualised parenting programme? - rather than how can parents benefit from access to professional knowledge and how can they refine this? Thus, despite their best intentions, the literature on parenting groups can perpetuate an oppressive model of practice which fails to address the wider socio-political determinants of the child's behaviour, fails to recognise the pathologising process produced by the application of the medical narrative and therefore perpetuates a model of parental blame.

This thesis develops this theoretical critique to explore how to run these groups democratically, humanistically and collaboratively and also systematically problematises the potential power imbalance. Cunningham et al's (1995) research

demonstrated that parenting work needs to be accessible and acceptable and that a non-didactic approach is more effective than a didactic approach and his findings will be discussed. Henggeler et al (1995) identified the need to bridge the gap between efficacy in research and effectiveness in practice settings and acknowledged the need to collaboratively identify solutions, which are relevant to carers and young people, with severe delinquency problems in their whole life space.

The unique contribution of nursing to health care is often identified as its provision of 24 hour care. The limitations of professional provision of 24 hour care when compared with the 24 hour responsibility of parents will be described. The question will be posed “Can nursing knowledge about 24 hour care inform the practice of parents when providing 24 hour care to children with challenging behaviours in their home context?” given that this has been identified as a deficit in the CAMH practice literature.

Chapter three provides a critical discussion of the rationale for the combination of methods and perspectives, which were employed to navigate a methodological pathway through the complex process involved in engaging in emancipatory research and practice with clients whilst simultaneously providing them with a service and aiming to develop a cumulative body of practice knowledge. The chapter explores how integrating an innovative combination of qualitative methods within a critical theory philosophy can refine the parenting narrative, how the parents’ narrative can impact on the professional narrative and how this impacts on the

narrative about the capacity of services to respond to children with challenging behaviours.

Chapter Four describes the methodological Process. Parenting groups were chosen for two reasons:

1. They potentially equalise one aspect of the power relationship as parents should outnumber facilitators.
2. Setting up parenting groups in the community provided a new clinical service as well as a research opportunity. There was a recognised service gap locally in the provision of parenting groups, despite evidence that such interventions have been shown to be effective in the treatment and management of children with challenging behaviours. This new clinical service was supported by the local service managers, once ethical approval was obtained from the local ethics committee.

The methodological dilemma of balancing the difficulties of recruiting to these parenting groups, reviewed in Chapter 2, alongside the benefits of attempting to recruit hard to reach groups is also considered in this chapter.

Chapter Five describes the previous nursing study (Croom 1996; Croom et al 2000) that this thesis builds upon and locates it within the PhD study. It will end with the propositions, derived from the nursing study, which structure the data analysis.

Chapter Six reports the findings of the thesis. A detailed analysis of the inductive analysis of the propositions with the parents is provided. The findings describe the key themes from the nursing framework, which the 25 actively participating parents found useful, those which they did not find useful and the additional contributions they brought to the original nursing framework and knowledge, through their experiences and analysis. The homogeneity of the findings that all parents suffered from tacit oppression will also be reported along with the a description of the socio-political factors, which provided an opportunity or constraint to the parents in being able to challenge this oppression. In addition, the ways in which parents developed their group consciousness and challenged the facilitators will be reported.

Chapter Seven is the first of three discussion chapters. It provides a critical analysis of the empirical findings in relation to the existing literature. The selection of literature used in the parenting groups will be discussed. The use of literature will be discussed in the context of the process of generating knowledge for practice and the problems and dilemmas this creates in selecting and using literature.

Chapter Eight is the Second Discussion Chapter. This Chapter considers why carers with 24 hour responsibility for children i.e. nurses (in the previous study) and parents (in this study) appear to have limited access to CAMH knowledge and limited opportunity to engage in its creation and dissemination. The implications for the development of CAMH services capacity to respond to children with behavioural problems are explored. In keeping with participant action research, an action plan arising from this study is presented. This takes the form of the Practice Framework (Appendix 2). The Chapter concludes with a description of the theoretical reasoning

on which the framework is based and a critical analysis of the broader social conditions necessary to underpin the practice change.

Chapter Nine, the final discussion chapter provides a personal critical reflection of what I have learned as a practitioner and researcher in undertaking this research. I consider how the work of critical theory such as Fontana (2004), Freire (1998) and Gaventa and Cornwall (2001) have helped to make sense of and develop the paradoxical situation of working simultaneously as a practitioner in the collaborative research process alongside the clinical role of CAMH worker with 'expertise'. In keeping with the principles of participative action research and critical theory, which explores 'what can be' and not 'what is' (Thomas 1993) and of practitioner research, which serves to improve practice while recognising the ongoing dynamic of practice change, this thesis is not an endpoint, but part of a dynamic process to generate further practice knowledge. The chapter concludes with a critical consideration of the implications for future practice and research opportunities.

Chapter 2 Literature Chapter

Introduction

This Chapter will review the evidence base of CAMH literature related to the prevalence and epidemiology of CAMH and specifically disruptive behaviour problems (DBP), the CAMH service context, providing 24 hour care in CAMH and working in collaboration with parents and carers of children with disruptive behaviour problems. This involved a search of the computerised data bases for nursing, allied health and medical literature including CINAHL, Medline and Proquest. The chapter will analyse the literature on working with parents of children with disruptive behaviour problems in order to identify the theory practice gaps and to provide a rationale for why this thesis aims to explore ways to address these gaps by working in participation with parents in order to explore how their capacity to respond to their children may be affected by to access and critique of a diverse body of information in their everyday context. The impact of current CAMH services will be critically reviewed and their limitations discussed.

The nature and scope of CAMH Problems

Epidemiological data demonstrates that internationally CAMH is characterised by high population needs and finite CAMH resources (Offord et al 1998; Meltzer et al 2000). Child and adolescent mental health problems represent a significant “burden of illness” (Offord et al 1998, p.686) to society as defined by the frequency of the disorder or condition, the short term and long-term morbidity and the costs in terms of

human and social distress and in fiscal terms. This burden is identified in UK advisory reports such as “Children in Mind” (Audit Commission, 1999) and “Bright Futures” (Mental Health Foundation, 1999).

An early attempt to identify the prevalence of CAMH disorders was undertaken in Canada. The Ontario Child Health Study (OCHS) was a community survey carried out to determine the prevalence of emotional and behavioural problems among children aged 4 to 16 in the province of Ontario, Canada (Offord et al 1989, Offord et al 1991). Of 2,052 households, which were eligible, 1,869 (91%) participated in the survey. It was a cross sectional survey whose main objective was to obtain unbiased estimates of the prevalence of four child psychiatric disorders (conduct disorder, hyperactivity, emotional disorder and psychosomatic disorders). Measures of physical health, family characteristics and socio-demographic variables and service utilisation were also collected in order to explore the co-relates of CAMH disorder (Boyle et al 1987). Prevalence rates of psychiatric disorder in children and adolescents was high (18.1%) and higher in urban populations (20%). Co-morbidity of disorders was found to be high and 68% of the children had more than one CAMH disorder. The presence of disorder was associated with psychosocial impairments e.g. family problems and academic difficulties were significantly associated with CAMH disorders. Despite this only a minority of children with psychosocial problems were seen by mental health services.

The OCHS study (Offord et al 1991) identified a number of child, family and community characteristics, which increased the risk of developing CAMH problems, for example having few friends, family problems, parental mental health problems

and poverty. Factors were also identified which appeared to protect the child against psychiatric disorders such as being a good student, getting along with others and participation in extra- curricular activities (Rae Grant et al 1989). The OCHS study had implications for clinical services and clinical training in terms of shifting the clinical focus from pathology to techniques for identifying and developing protective factors and reducing risk factors and a greater focus on prevention (Rae grant et al 1989)

In 1999 The Office of National Statistics carried out the first major UK wide epidemiological study of CAMH problems (Meltzer et al 2000). They undertook a survey of 5-15 year olds in England, Scotland and Wales between January and May 1999 (Meltzer et al 2000). The survey identified that the prevalence of known child and adolescent mental health disorders is around 10%. Only about a third of children with behaviour problems sought help and of these about 58% said they initially sought help from their mothers or fathers (28%) and “overall a small proportion had asked for help from professionals” (Meltzer et al 2000 p.120).

Internationally, epidemiological studies (Meltzer et al 2000; Bird et al 1988, Offord et al 1987, Bird 1996) indicate that only a minority of children with diagnosable problems (1 in 6) have professional consultation. Because of under-reporting the prevalence is hard to estimate. The Mental Health Foundation proposes that the prevalence of CAMH problems is at least 20%, because many children do not receive a diagnosis or come into contact with CAMH services. Rae Grant (1994) worked on various epidemiological studies of CAMH and proposed that “Even if all of the children and adolescents with disorders who require and would accept treatment,

could be offered treatment, therapeutic methods are very expensive, time consuming and require highly trained personnel and in the foreseeable future, there will never be adequate resources. Other means of reducing the risk for disorder in the childhood population must be found. Despite the evidence for the enormous discrepancy between needs and resources and the obvious need to reduce the prevalence of CAMH disorders, prevention programmes and training programmes have been slow to develop” (Rae Grant 1994).

A major source of concern to CAMH services (Cunningham et al 1995 and 1998) are disruptive behaviour disorders and disruptive behaviour problems (DBD/DBP). These include disorders which can be diagnosed in the International Classification of Diseases 10 (WHO 1993) and the Diagnostic and Statistical Manual IV (American Psychiatric Association 1994). The symptoms of disruptive behaviour disorder are briefly described below:

Attention Deficit Hyperactivity Disorder (ADHD) characterised by a persistent pattern of inattention in academic, school and social situations, hyperactivity, restlessness and impulsivity, which is more severe than typically observed in individuals at a comparable level of development.

Oppositional Disorder characterised by a recurrent pattern of negativism, defiant, disobedient and hostile behaviour towards authority figures.

Conduct disorder in which there are repetitive, persistent patterns of behaviour in which the rights of others or major age-appropriate social norms/rules are violated.

Behaviours may manifest in terms of physical harm directed at others or animals, deceit and theft or serious violations of rules.

In the Office of National Statistics study, the prevalence of behaviour disorders in ages 5-15 in the UK was estimated as 6% (Meltzer et al 2000). The prevalence of conduct disorders between the ages of 5 years and 10 years was estimated at 1.7% for boys and 0.6% for girls (Meltzer et al 2000). The prevalence of oppositional defiant disorders in 5-10 year olds was estimated at 4.8% for boys and 2.1% for girls (Meltzer et al 2000). Robins (1966) found that the median age of onset for children referred to mental health clinics was in the 8-10 year age range. 57% of boys referred to services had an onset before the age of 10 whereas the onset for girls was mainly between 14 and 16 years of age (Meltzer et al 2000). It is acknowledged that there is a gender difference in the presentation of behaviour disorders between boys and girls, although there is little research to provide any empirical reasons for this. This thesis does not focus on the gender differences in any depth, although it is recognised that it is an important area, worthy of a PhD in its own right. The focus of this thesis is on developing ways of increasing the capacity to respond to children with challenging behaviours in a context of high needs and finite resources, through collaborative research with parents.

In order to be diagnosed with a disorder, the severity of the child's symptoms must be considered to be of such an intensity that they are interfering with his/her social, emotional and/or physical development, cause significant distress to the child and family on a daily basis, interfere with their everyday functioning and the duration of these effects must be longer than 2 weeks (Pearce 1993). The Pearce (1993) criteria

has been adopted by national reports including the Health Advisory Service Report (1995) - *Together We stand*, which was the first comprehensive UK Report on CAMH services and has become the platform upon which other policy reports have built including the National Service Framework for Children, Young People and Maternity services (DoH and DfES 2004).

Personal Family and Social Consequences of CAMH problems

The high incidence of disruptive behaviour problems and the burden of illness this represents creates additional problems not just for the child but for their family and community (Kazdin 1995, Knapp et al 1999).

Children with disruptive behaviour problems and disorders place an enormous burden on family relationships because the challenging nature and negative quality of their interpersonal relationship with parents and siblings increases the level of stress and tension within the family system (Mash and Johnson 1982 and 1983). In addition children with DBD/DBP have and cause significant problems among peers because of their challenging interactions and hostile interpretation of peer's actions, which can lead to aggression (Cunningham et al 1995). The disruptive behaviour of these children in classroom and playground situations places an increased burden on teachers (Whaler 1980).

There is evidence that children with disruptive behaviour problems elicit a much more controlling and less positive response from parents, teachers and peers (Barkley et al 1987). This may compound the child's difficulties (Patterson 1982 p. 122) and adversely influence the longer term adjustment (Earls & Jung 1987).

Research literature reports that parents of children with disruptive behaviour problems frequently find that their parenting techniques are inadequate and eventually report a limited sense of control over the child's behaviour (Sobol et al 1989). This sense of learned helplessness and failure leads to a reported lower sense of self esteem (Mash and Johnson 1983). Parents report that they feel increased stress because of their difficulty in coping with their children and their demands and aggression (Anastopoulos et al 1992). Parents report a profound sense of social isolation because they feel ashamed and ostracised by their child's unsociable and frequently antisocial behaviour (Cunningham et al 1988). Parents of children with disruptive behaviour problems and disorders also report higher depression scores (Cunningham et al 1988).

Furthermore, if children with disruptive behaviour problems and their families are not supported with preventative and early intervention strategies, evidence from research demonstrates a potentially poor prognosis and persistence of problems into adult life (Offord 1996; Barkley et al 1990).

Thus, children with disruptive behaviour problems not only suffer significant personal distress, which impacts on their development, but their difficulties can also impact on families, teachers, schools and the community and this "burden of suffering" can be long term. Although disruptive behaviour problems constitute the majority of referrals to CAMH specialist outpatients, a significant percentage of children are not identified/referred and do not receive treatment (Offord et al 1987, Meltzer et al 2000). This means that for many children, their families and the community they live in, their problems go undiagnosed and can be misunderstood by those who work with them.

Risk and Resilience in CAMH

It is widely recognised in the CAMH literature that the challenging behaviours associated in children with disruptive behaviour problems and disorders can be best understood by the application of a risk and resilience model (Place et al 2002; Haggerty et al 1996; Offord 1996). The identification of risk and resilience CAMH has drawn predominantly on the use of statistical and regression analysis in which the factors pre-disposing to CAMH problems are derived by comparing the social and familial characteristics of children diagnosed with problems against a matched sample of children not experiencing these problems (Garmezy and Rutter 1983, Werner 1989). Garmezy and Rutter (1983) defined risk factors as those factors, which if present, increase the likelihood of a child developing an emotional or behavioural disorder in comparison with a randomly selected child from the general population. These factors include biological and genetic attributes of the child as well as family and community factors, which influence the child and their family environment. Rutter (1993) defined protective factors as “those factors that modify or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome in such a way that protects them from developing the disorder or adopting the maladaptive behaviour traits. Garmezy and Rutter (1983) summarised protective factors as a positive personal disposition, a supportive family milieu and an external societal agency that functions as a support system for strengthening and reinforcing the child's coping efforts”. Rae Grant et al. (1989) found that in statistical terms, family problems and parental problems heighten the risk for disorder, whereas being a good student, getting along with others and participation in activities reduced the risk of disorder.

Extensive research in the field of CAMH has identified a range of risk factors, which increase the vulnerability to developing CAMH problems and disorders and protective factors, which protect against the onset of problems or disorders, even in situations of adversity (Pearce 1993; Bird 1996; Offord et al 1989; Rae Grant et al 1989). The impact of these factors on the mental health of children appears to depend on the accumulation of risk factors at an individual, family and community level to which a child/family is exposed (Meltzer et al 2000, Offord et al 1989). Rutter (1999) proposes that it is the accumulation of risk factors and stresses that create the most harmful effect on children's functioning. Accumulation of risk factors associated with DBD/DBP with the absence of protective factors leads to an increased probability that a conduct disorder will develop (Kazdin 1995).

A range of risk factors, which specifically increase the likelihood of a child developing DBD/DBP, have been identified in terms of the child, family and environmental factors. The goal of intervention is to change the balance between the adverse effects of risk factors and the beneficial effects of protective factors (Rae Grant 1994). Because the factors are derived using statistical techniques such as regression analysis, no distinction is made between factors for which an intervention is feasible such as poverty and factors which cannot be changed, such as gender. It is not unusual, therefore to find research on risk and protective factors in CAMH which span a wide range of diverse literatures including temperament, delays in language development and cognitive functioning, poor social skills, neglect, abuse, harsh, lax or inconsistent discipline and parental depression. Each of these will be briefly reviewed below.

Risk factors Pre-disposing to developing disruptive behaviour problems and disorders in children and adolescents.

A number of studies have suggested that infants assessed as having a difficult temperament are more likely to show problems with behaviours in later life (Greenberg and Spelz 1993). A difficult temperament may make children more likely to be the subject of parental anger, which in turn may be linked to conduct disorders later on (Marshall and Watt 1999). Temperament refers to a number of characteristics that show consistency over time (Normand et al 1996). A study of temperament and development found parents who perceive their children to have difficult temperament characteristics; particularly negative mood and high intensity of emotional expression have less satisfying parenting experiences (Chess and Thomas 1989; Sheeber and Johnson 1992 and 1994).

Tschann et al (1996) found an association between difficult temperament characteristics including distractibility, persistence, extreme levels of activity, negative mood and high intensity of emotions with both internalising and externalising challenging behaviours. This was highest for children living in families where there were high levels of conflict (Tschann 1996). Sheeber and Johnson (1992) looked at the applicability of a family scale for assessing parents with behaviourally difficult children. They found that parents with temperamentally challenging children report more negative affect, less self-confidence in parenting and greater dysfunction in family functioning than do families of temperamentally easier children. However, there appears to be little research, which has explored with parents how useful they

would find accessing the literature on temperament to managing their children in their everyday context

Other studies have examined the cognitive co-relates of conduct disorder in younger children and have found that they have delays in language development, information processing and cognitive functioning (Cantwell and Baker 1991; Hinshaw 1992).

Scott (1995) emphasises the importance of working with educational underachievement due to cognitive deficits because under achievement leads to escalating feelings of low self esteem in the child. However, research has not been carried out to explore how or whether disseminating information on cognitive functioning with parents could be useful to them in their everyday care.

Rutter (1988) found that children with chronic illness have three times the risk of experiencing DBD/DBP. Kazdin et al (1992) found that poor social skills in children with DBD/DBP often led to difficulties with friendships and peer groups.

Risk factors have also been identified at the parenting level. Carr (1999) identifies that neglect, abuse, separations, lack of opportunities to develop secure attachments and harsh, lax or inconsistent discipline are among the most important parental child factors which increase the likelihood of a child developing DBD/DBP. Parental depression is one of the strongest predictors of conduct disorder. Scott (1998) identified 5 aspects of child rearing that have been repeatedly shown to be associated with conduct disorders:

- Poor supervision
- Erratic harsh discipline
- Parental disharmony

- Rejection of the child
- Low parental involvement in the child's activities

Webster-Stratton and Spitzer (1991) found that parents of children with conduct disorders lacked fundamental parenting skills and exhibited less positive behaviour towards the child. Their discipline was found to involve more violence and criticism, they were more permissive, erratic and inconsistent with limit setting and were more likely to punish negative behaviour and ignore pro-social behaviour (Webster Stratton and Spitzer 1991) Patterson (1982) and Patterson et al. (1989) also identified that parents of antisocial children are deficient in their child rearing skills. This included not telling the children how to behave, failing to monitor the behaviour of children and failing to enforce rules promptly.

Loeber et al. (1993) demonstrated that children who became violent as adolescents could be identified with almost 50% reliability as early as 7 years of age. Studies have shown that approximately 40-50% of children with conduct disorder go on to become anti-social adults (Rutter and Giller 1983; Rutter et al 1998).

Research indicates a strong link between disruptive externalising behaviours in pre-school years and externalising behaviours in adolescents (Rutter 1985; Loeber 1990).

It is hypothesised that the early onset pathway begins with the emergence of oppositional and defiant behaviour in pre-school and progresses to both aggressive and non aggressive behaviours (such as lying and stealing) associated with conduct disorders in middle childhood and adolescence. The research also indicates that there is a particularly poor prognosis following the early onset of these problems and indicates the need for early intervention (Scott 1998).

The above evidence forms the foundation for the assessment and treatment of disruptive behaviour problems and disorders in CAMH problems in contemporary western health care. The statistical methods used to derive the risk and protective factors preclude a more critical theoretical approach to the identification of the evidence base. It is apparent from the brief review given above that these factors could pre-dispose to a parent blaming interpretation of the aetiology of these disorders and that professional interventions need to theorise the interpretation of these factors if professionals consider it important to avoid a parent blaming approach.

Resilience and CAMH practice

Although the mental health services provided to children over the past 10 years, have grown and increased in sophistication, most of the effort has focused on responding to difficulty and disturbance rather than prevention and a key practice question is ‘why do some individuals appear more resilient in the face of adversity than others’ (Place et al 2002). There are numerous definitions of resilience, but the descriptions show common themes i.e. the ability to bounce back despite adversity (Stewart et al 1997), to “spring back” (Jacelon 1997, p.76) or ‘to adapt successfully despite the presence of significant adversity’ (Beardsley et al 1998, p.1134). Resilience can also be seen as a dynamic state that enables an individual to function adaptively despite stress by using protective factors to moderate encroaching risk factors (Cicchetti and Rogosch 1997, Rutter 1999). Children’s resilience or ability to bounce back and function adaptively has been examined in relation to a range of risks including poverty (Cowen et al 1996; Garmezy 1991) abuse and neglect (Cicchetti and Rogosch 1997) and parental mental illness (Beardsley et al 1998). Such stressors can have a significant impact on

children's lives as illustrated by a study in which only about a third of children who had lived with poverty, parental mental illness and relationship breakdown developed into caring, competent adults (Werner 1989).

In order to utilise the concept of resilience in a therapeutic way, it is therefore essential to identify and apply the literature on specific risk and protective factors. A range of protective factors have been identified in the literature and demonstrated that children who show strong resilience have access to protective mediating factors, when faced with risk or adversity and that these protective factors can operate at an individual, family and community level (Garmezy 1983, Rutter 1999)

At an individual level, the following protective factors have been identified: high self esteem (Bell and Suggs 1998), ability to process information including the ability to self reflect (Cicchetti and Rogosch 1997), to problem solve (Garmezy 1993), to interact positively with others (Cowen and Work 1988) and engage in extra school activities (Garmezy 1993).

At a family level, factors which appear to promote resilience are related to the relationship that the parents have with their children including a pattern of family interaction, which is warm, cohesive and supportive of family members (Cowen and Work 1988; Sandler et al 1992) and this is particularly strengthened when the child feels there is a strong bond with the parent (Cowen et al 1996).

At a community level, protective factors include the support of an adult outside of the family to act as a role model (Cowen and Work 1988) and a positive experience within schools (Hechtman 1991, Rutter et al 1979).

The above literature indicates that in order to promote the capacity to respond to CAMH problems, it is crucial to reduce the risk factors and promote the protective factors. Furthermore, exploring the complex and global set of risk and protective factors that children and parents are subjected to, may provide a way of analysing the needs and strengths of children and families without resorting to a parent blaming model. However, there is little research, which has applied this risk and resilience literature to actual practice situations. Place et al (2002) published the findings from a pilot programme in which 10 families (all parents had an identified mental illness but no child had an identified mental health problem) were given an intervention package in order to promote their resilience. This included a skills group for the children and a group for the parents. Although the results were very positive in terms of improved adaptive functioning of both parents and children, further follow-up work is necessary. However, there appears to be little research, in which the literature on risk and resilience has been shared with parents in order to explore if they find access to this information to be useful and empowering or whether professionals can develop the use of risk and resilience research in order to build on strengths rather than deficits (and thus promote CAMH or respond to CAMH problems /disorders) through collaborative research with rather than on parents.

Service Responses to the CAMH evidence base

The National Service Framework for children, young people and maternity services (DoH and DfES 2004) and the government white paper 'Every Child Matters' (DfES

2003) specifically discuss the need to make CAMH services accessible and acceptable to young people and their carers.

The application of triage to CAMH is increasingly becoming an important concept in optimising limited CAMH resources (Gale and Vostanis 2003); particularly in primary care where CAMH workers attempt to be a bridge between primary and specialist services. The need to develop responsive services arises partly out of growing concern about the length of waiting lists in CAMH services. Rawlinson and Williams (2000) discuss the literature base, which shows that as referral rates increase, waiting lists also increase. Increased waiting times lead to a decrease in attendance and the resulting wasted appointments which leads to a further increase in waiting times. This kind of escalating pressure on services indicates the need to continue to develop innovative ways to increase the service capacity.

In 1995, the Health Advisory Service (1995) proposed the introduction of a tiered model of service provision based on the principle that services should be structured to provide the least invasive care in the least intensive setting, commensurate with effectiveness. Children should only be referred to the next tier if it is evident (through some form of standardised assessment procedure) that their needs cannot be adequately met at a less invasive level. Tier 1 refers to primary level CAMH care. Tier 2 is provided by specialist individual professionals working in partnership with generic primary care workers such as GPs, Health Visitors, teachers, school nurses. Tier 3 refers to a specialist multi-disciplinary community/day centre and outpatient services for more complex disorders and tier 4 refers to tertiary level services such as in-patient units.

Box 1

Exhibit 1

Key components, professionals and functions of tiered CAMHS

Mental health services for children and adolescents have been described according to a four-tier framework

Tier 1 – A primary level, which includes interventions by :

- GP's
- Health Visitors
- Residential social workers
- Juvenile justice workers
- School nurses
- Teachers

These non-specialist staff:

- identify mental health problems early in their development
- offer general advice – and, in certain cases, treatment for less severe mental health problems
- pursue opportunities for promoting mental health and preventing mental health problems

Tier 2 – A level of service provided by professionals working on their own who relate to others through a network rather than within a team:

- Clinical child psychologists
- Educational psychologists
- Paediatricians – especially community
- Community child psychiatric nurses or nurse specialists
- Child psychiatrists

CAMHS professionals offer:

- training and consultation to other professionals (who might be within Tier 1)
- consultation for professionals and families
- outreach to identify severe or complex needs where children or families are unwilling to use specialist services
- assessment which may trigger treatment at this level or in a different tier

Tier 3 – A specialist service for the more severe, complex and persistent disorders

- Social workers
- Clinical psychologists
- Community psychiatric nurses
- Child and adolescent psychiatrists
- Art, music and drama therapists
- Child psychotherapists
- Occupational therapists

This is usually a multidisciplinary team or service working in a community child mental health clinic or child psychiatry outpatient services and offering:

- assessment and treatment of child mental health disorders
- assessment for referrals to Tier 4
- contributions to the services, consultation and training at Tiers 1 and 2
- participation in research and development project

Tier 4 – Infrequently used but essential tertiary services such as day units, highly specialised outpatient teams, and inpatient units for older children and adolescents who are severely mentally ill or at suicidal risk

This approach is designed to ensure that children receive the most appropriate help

whilst using the optimum combination of resources at the least invasive level of

provision. A similar model is proposed by Offord et al (1998) in Canada which is

designed to provide an optimum combination of CAMH universal, targeted and specialist services. This is described below:

- **Universal services:** These are community preventative and health promotion programmes, which can be accessed by all children and families in the local population. The advantage of such programmes is that they are non-stigmatised services and can be adapted to meet local population needs. In Canada these services include access to public health nurses, family physicians, parenting groups such as the COPE programme (Cunningham et al 1995) which are advertised to and can be accessed by parents in the whole community; social skills groups and school mediation groups for whole school populations (Cunningham et al 1998); summer camps and sports recreation programmes (Offord 1996) and the youth net programme (Davidson and Manion 1996) which is offered to all adolescents, for example in schools to support their insight and understanding of mental health issues, promote their coping skills and provide access to specialist CAMH services for those with identified need. The disadvantage of universal services includes the difficulty of achieving equal utilisation by all those who could benefit because the impact of universal services on a population depends on maximum utilisation. A further disadvantage is that offering services to whole populations, most of whom do not have CAMH needs, is potentially expensive and inefficient.

- **Targeted programmes:** programmes for those children and families, who are identified as vulnerable. These include those children of families with a multitude of risks/vulnerabilities to developing CAMH problems at an individual, family or environmental level and an imbalance of protective/resilience factors. In Canada, targeted CAMH programmes include having smaller, more intensive groups in schools for those children who require more intensive support than provided by the universal groups (e.g. children with poor social skills, problems with disruptive behaviour problems), and extra support and encouragement given by professionals to vulnerable parents who would not normally attend parenting groups, extra public nursing home support (Rae Grant 1994). The advantages of targeted programmes are that they can be efficient, the intervention is tailored to the vulnerability and they can address problems early. The disadvantages are that the potential labelling and stigmatisation of children and families can make it difficult to ensure uptake amongst those most at risk, it can be difficult to target accurately and screening to identify vulnerability can be expensive (Offord et al 1998)
- **Clinical programmes:** for those who cannot be helped by universal or targeted interventions and who require specialist CAMH services in clinics, day-patient or residential services such as those offered in specialist and tertiary CAMH units. The advantages of these services include their potential efficiency at tailoring need to identified problems. The disadvantages include the labelling and stigmatisation, the expense of

offering services to individual clients and the difficulty in meeting population need, when the prevalence is 20% (Offord et al 1998).

Offord et al (1998) argues that in a system of finite resources and high need, there will always need to be a compromise or trade off between universal, targeted and specialist services. Offord et al's (1998) model highlights the importance of universal services as the first tier of provision designed as a preventative strategy, which enhances the capacity of the community as a whole to engage with these problems and so normalises the behaviours and reduces stigmatisation.

In the UK the importance of meeting the mental health needs of children and adolescents is recognised in the National Service Framework (NSF) for Children, Young People and Maternity Services (DoH and DfES 2004). This recognises the high prevalence and high burden of illness in CAMH.

Standard 9 of the NSF for Children, Young people and Maternity services refers specifically to "The Mental Health and Psychological well being of children and young people". Standard 9 states:

"All children and young people from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support for them and their families" (DoH and DfES 2004, p. 33).

The supporting documentation for Standard 9 of the NSF reveals that the vision behind the standard is to improve the mental health of all children and young people and for children, young people and their families to have access to mental health care based upon the best available evidence. Standard 9 highlights the need to improve service provision at all levels from universal services (available to all) to targeted services (for those at risk of developing a problem) to clinical services (for those with an identified disorder). It endorses the four tiers of provision, proposed by the Health Advisory Service (1995) described above.

Standard 9 of the NSF for Children, Young people and Maternity services (DoH and DfES 2004) states that the views of users must be systematically sought and incorporated into reviews of service provision and that service providers and commissioners must develop proposals for user involvement of children, young people and their parents or carers. However, the NSF does not give guidance on how to authentically gain user involvement, nor does it discuss the tensions involved in working as service providers in a relatively privileged position whilst simultaneously collecting user views. Standard 9 also discusses the importance of increasing the total system capacity to respond to CAMH issues through multi-agency partnerships and partnerships with voluntary agencies. It does not, however, discuss the strategies for promoting partnership with parents, who arguably provide the greatest amount of care to children with challenging behaviours. The concept of involving users in negotiating care needs is repeatedly raised in the policy literature (DoH and DfES 2004), but the processes required to meaningfully operationalise this in a service setting are not critically analysed.

The NSF standard 9 (DoH and DfES 2004) states that discharge planning should receive equal attention to admission planning. An implication for in-patient nurses, therefore, is that the nursing knowledge and skills that have been employed in the 24 hour care of the children must be shared and disseminated with parents. However, there is a dearth of literature related to the dissemination of nursing skills and knowledge in CAMH, despite the NSF standard nine, which states:

“The in-patient unit needs to be able to hand over to an appropriately equipped community service. There needs to be a shared understanding of the level of care required on discharge from in patient services and if the appropriate resources are not available in the community there may be a continued role for the inpatient team in the provision of outreach services” (NSF standard 9, p.34)

It is perhaps significant that parents are not mentioned as part of the community team on discharge. Furthermore, standard 9 states that “the provision of mental health care for children, young people and their families can be demanding for staff, who work with them and who therefore need to have support mechanisms in place” (NSF Standard 9, p. 35), but the stress of parents looking after challenging young people in the community is not identified. Despite the rhetoric of user involvement in the NSF for Children, Young people and Maternity services, the omissions described above indicate a lack of clarity on the part of policy makers and service providers as to what this means in practice. This thesis attempts to critically respond to these omissions by creating a practice situation where parents are seen as creators and providers of services for children, rather than just service users.

Cost of services

A major concern for service providers and commissioners of health care is the cost of service provision for children and adolescents with mental health problems. It is recognised that the cost of disruptive behaviour problems and disorders such as conduct disorders, both in terms of those who have disorders (and the people around them) and in terms of the resources necessary to counteract them is high (Knapp et al 1999). Very little health economic research into CAMH services has been undertaken in the UK.

One of the few UK economic studies on CAMH has been conducted by Knapp et al (1999), who identified that the NHS resources spent on children with conduct disorders are considerable. Knapp et al (1999) describes how 30% of child consultations with GP's are for conduct disorders. 45% of community child health referrals are for behaviour disturbances, with an even higher level for children with special needs or developmental delay. Social services departments expend energy trying to protect disruptive children, whose parents can no longer cope without hitting or abusing them. Education costs include funding for special schools and law enforcement agencies and the probation services have to detect and bring young offenders to justice (Knapp et al 1999).

The rate of unemployment and receipt of state benefits is also high among young people with conduct disorders (Rutter et al 1998). Research has thus demonstrated that all agencies spend considerable amounts of money in supporting a child or young person with conduct disorder over the lifespan if nothing is done to treat the child. Knapp et al (1999) calculated that the total direct costs annually for all agencies for

treating conduct disorder was £8,258 and the indirect costs including loss of employment for parents, additional housework and repairs, allowances and benefits was £7,012. The total cost annually per child was likely to be £15,270 and increased costs for care and to society in later years is likely to result from the diagnosis of conduct disorder. A fiscal case can therefore be made, alongside a social and therapeutic one, for finding innovative ways of working with and engaging in collaborative research with parents of children with disruptive behaviour problems that can include or lead to conduct disorders.

Inequalities in Access to CAMH Services

The literature indicates that there is a need to develop ways of responding to behavioural problems by working with young people and their families across the total set of systems with which the family interact (Henggeler et al 1995). It is increasingly recognised that the traditional way of identifying and treating children on a one to one individual basis cannot be expected to reduce the burden of suffering at a population level for a number of reasons.

Firstly, the number of children with clinically important psychiatric disorders far exceeds, sometimes by factors of 10 or 20, the ability of the clinical services to assess and treat them (Offord and Bennett 1994, Boyle et al 1987).

Secondly, the literature indicates that there are difficulties in achieving compliance with traditional CAMH approaches, as between 40%- 60% of families who begin treatment because their child has emotional or behavioural problems, withdraw from treatment prematurely (Kazdin 1997).

Thirdly, because of escalating demand and problems with lengthening waiting lists (Rawlinson and Williams 2000) the time interval between the parents seeking help and actually receiving help may be considerable and during this period, the problems can become more entrenched and intractable (Offord and Bennett 1994).

Fourthly, although progress is being made in discovering efficacious treatments for child psychiatric disorders such as early onset conduct disorders, under controlled clinical conditions, there is little evidence of the effectiveness of these treatments when they are mainstreamed into the practice setting (Kazdin 1995, Offord and Bennett 1994). For instance, Henggeler et al (1997, p. 821) noted “that the efficacy of child psycho-therapies observed in research settings has rarely transferred to effectiveness when delivered in the community.”

The literature thus appears to indicate that there is a need to find effective and innovative ways of increasing the capacity to respond to children with behavioural problems as clinical services alone cannot meet the demand of children with behaviour problems, increasing waiting lists can exacerbate problems, and inequalities in access by those most in need coupled with a high dropout rate mean that clinical services are ineffective at treating those with the most problems.

It would appear that the inverse-care law first described by Tudor-Hart (1971) is still influencing service provision in CAMH. This law recognises that those most in need receive the least input from our publicly funded services, while those who are already privileged not only make greater use of the services, but benefit from the secure jobs and pensions they provide. As a result, services are more geared to meeting the needs

of privileged users and less able to accommodate the needs of those at greatest risk. This indicates there is a need to innovatively explore therapeutic strategies which are accessible for and acceptable to families, who frequently drop out of conventional treatments.

Parenting Programmes in CAMH

Parenting programmes have been found to be particularly important for families of children with disruptive behaviour problems and attention deficit hyperactivity disorders, who, if left untreated, may go on to develop more severe problems such as conduct disorders and then engage in antisocial behaviours. The consequences of this are that parents, schools and society must then cope with increasing social, psychiatric and legal problems during adolescence (Barkley et al 1990). Parents of Attention Deficit Hyperactivity Disorder and Conduct Disorder children report more mental illness, marital conflict, family dysfunction and social adversity (Szatmari et al 1989). Parent training programmes have been demonstrated to improve child management skills (Barkley et al 1992), reduce primary Attention Deficit Hyper Activity symptoms (Barkley et al 1992), improve secondary behaviour problems associated with ADHD, (Freeman et al 1992) and parents report increased confidence (Webster-Stratton, 1998), reduced stress (Webster-Stratton 1998) and improved family relationships (Barkley et al 1992).

In addition to this, follow up provides evidence that the effects of parent training are maintained over intervals of six weeks (Freeman et al 1992), two months (Anastopoulos et al 1992) and nine months (Dubey et al 1983).

Thus the efficacy of parent training programmes as an intervention is established in the current evidence base as an effective therapeutic intervention, when studied under experimental conditions. However, despite the apparent efficacy of parenting groups, which have been demonstrated in Randomised Controlled Trial research, there are limitations in the ways which parenting groups can impact on clinical effectiveness when applied to practice populations. Even when parenting programmes are available, attendance is limited (Cunningham et al 1995). With parents who attend parenting programmes, there is a dropout rate of at least 25% (Forehand et al 1983).

The poor attendance and dropout rate is increased with economically disadvantaged, socially isolated, single and depressed parents, whose children are also at the greatest risk (Cunningham et al 1995). Puckering and Evans (1996) argue that “dysfunction in the parents and the lack of social support may obstruct their appropriate access to and use of services for children”. Pugh and Smith (1996) in a major survey of UK based parenting groups reported that most programmes attracted white middle class women and they acknowledged the difficulties of attracting a wider cross-section of parents. Parents who are more likely to be socially excluded such as economically disadvantaged and socially isolated (Whaler, 1980) and single and depressed parents (Webster-Stratton & Hammond, 1990) are more likely to discontinue or not access the programmes.

All of the above gives rise to a tendency for services to engage in selective provision for better off parents. The difficulty in engaging the most vulnerable, hard to reach parents and the high dropout rate indicates that there is a need to do more work to engage parents in a process, which is acceptable to and accessible for those parents in

greatest need. Furthermore, the CAMH research undertaken so far appears to have focused on determining clinical efficacy from the point of view of the experts. There is little CAMH research, which has involved parents as active participants to discover which of the knowledge and skills in the group programmes (such as the programmes proposed by Cunningham et al 1995 and Webster-Stratton 1998) they found helpful, how parents adapt these skills to their 24 hour context, what other literature may be helpful to them in their context and how parents themselves can add to a cumulative body of practice knowledge and skills and thereby increase professionals' capacity by developing their understanding and insight into their lived experiences.

The Structure of Parenting Programmes

Cunningham et al (1995) discuss the importance of taking a non-didactic approach with parents in parenting programmes. In order to facilitate this, he advocates a set of cognitive attributional questions with parents in order to develop their insight and motivation to change (see box 2). Cunningham et al's (1998) attributional questions were incorporated in this thesis to gain parents motivation and participation. The COPE (Cunningham et al 1995; Cunningham et al 1998) programme is a well established evidenced based parenting programme. Its principles are described in Box 3 below:

Box 2

<u>Cunningham et al 1996</u>	<u>Cognitive Attributional Questions</u>
•	What difference does it make when you solve problems this way?
•	What do you teach kids by solving problems this way?
•	What do you say to each other by solving questions this way?
•	What would be the long term effect of solving problems this way?
•	Is it worth the effort to solve problems this way?

1.	Introduction, information about group and setting of aims and ground rules.
2.	Helping parents to pay attention to their children and communicate on positive aspects of their behaviour.
3.	Planned ignoring of behaviours to avoid constant confrontations.
4.	Setting limits
5.	Use of “when/then” warnings e.g. when you’ve tidied your toys, then you can watch TV.
6.	Giving clear instructions about limits
7.	Planning ahead so that children know in advance what is expected of them in situations
8.	Application of behavioral principles: use of positive reinforcements and charts
9.	Use of “Time out” i.e. withdrawing attention completely from child
10.	Problem solving

Each of these principles are worked through with the parents on a weekly basis and parents are supported to problem solve parenting difficulties associated with each of the above principles. However, Cunningham et al’s (1998) COPE programme approach could still be argued to be expert led. Although the approach is non-didactic, there is not a reciprocal sharing of the diverse published literature with the parents and the parents are not encouraged to contribute to the knowledge base or refine the parental manual. Instead the COPE programme adopts a deficit model in which it assumes that improvements in clinical outcomes will only occur if parents comply with the structure of the parenting programme, outlined in the associated manual. Webster-Stratton (1998) uses a similar parenting programme structure, which is outlined in a manual and advocates strict adherence to the manual.

The parenting programmes (Cunningham et al 1995, Webster-Stratton 1998, Patterson 1982) thus tend to be underpinned by assumptions that there are deficits in the parenting practices of the participants that need to be changed. They do not explore how professional's information or assumptions need to be challenged in order to provide a more supportive and emancipatory community milieu for the parents. Although the CAMH literature describes how to run these groups collaboratively and in a non-didactic way (Cunningham et al 1995; Webster-Stratton 1998), it does not recognise the impact of the potential inequality of power on the dynamic of the parenting group situation neither does it theorise the impact of this power differential on the attempt to implement non-didactic practices.

Instead, the traditional parenting research tends to use a manualised approach to disseminate the methods used. This approach does not address how parents can directly refine and contribute to the manual or the wider field of knowledge. This creates a tension in the use of collaborative approaches, which is not critically discussed in the CAMH literature. Thus research into parenting groups tends to ask the question - how replicable and generalisable is the manual or practice? - Rather than how can parents benefit from access to professional knowledge and how can they refine this? Although Cunningham et al's research (1995) highlights the importance of making parenting group programmes accessible and acceptable to the population to be served, the problems of accessibility and the acceptability of expert knowledge, which takes a pejorative view of parenting behaviour, is not theorised in the CAMH literature. Nor is it used to understand problems of low take-up of services by those most in need and the high dropout rate which characterises most CAMH provision. This thesis incorporates the evidence base on parenting programmes, but in addition

shares a diverse knowledge base with parents in an inductive process, so that rather than “teaching” parents or replicating a manual, the parents are encouraged to explore to what extent the evidence base on parenting children with DBP is useful or not. In addition in this thesis, other literature related to challenging behaviours such as temperament and information processing is directly shared with parents and subsequently explored for its relevance to the 24 hour care of their children.

However, “Much of what passes for research on evidence based practice in the field of child and adolescent mental health might more aptly be described as clinical treatment efficacy research” (Hoagwood et al 2001, p.1180). In the field of children’s mental health services research, the term evidence based practice refers to a body of scientific knowledge about service practices - for example referral, assessment and case management- or about the impact of clinical treatments or services on the mental health problems of children and adolescents. The knowledge base is created through the application of scientific methods that examine the impact of certain practices on outcomes for the child or adolescent and his or her family. Using this perspective the problem is located with the family and the service or practice response is to treat the child and their family using evidenced based standardised techniques” (Hoagwood et al 2001),

Hoagwood et al (2001) carried out a review of these practices in CAMH and found that “... the literature in the efficacy of a range of child and adolescent treatments is uneven, although it is gaining strength. However, the evidence for the effectiveness of either clinical treatments or services within practice settings as opposed to research settings is still weak. Improving the evidence will require attention to service

variables that tend to be neglected in most efficacy based studies” (Hoagwood et al 2001, p.1180). This problem results from the strong experimental focus which dominates CAMH research. The need for standardisation of intervention within this approach makes it difficult for researchers to accommodate individual difference or context.

Hoagwood et al (2001) argue that this weakness is premised on a presupposition that: “the development of the evidence base has taken into account the fit between the treatment and the context of delivery. In fact, this has been attended to only rarely.

One reason that efficacy studies, which constitute a significant portion of the evidence base in children’s mental health, have not been readily deployed in service settings may be that the theory, methods and models used to develop, refine and test those treatments do not mesh well with the exigencies of clinic based or community based care.... There has been an implicit assumption that once the laboratory studies of the efficacy of treatments have been completed, the results will be usable and relevant. However, the conditions under which most research is conducted differ in numerous ways from those in which everyday treatment is delivered” (Hoagwood et al 2001, p.1181).

There is thus a theory practice gap identified in applying research derived from the experimental conditions of the emperico analytical paradigm dominant in medical research to actual practice situations. However, this gap has been identified from the perspective of professionals using this research and not from those undertaking research in CAMH. There is very little research which has been carried out to explore the practice theory gap between the efficacy of research conditions and the actual

lived experiences of children with challenging behaviours and their parents in the community.

Despite these findings, a plethora of community initiatives have been introduced to support children with mental health problems and their families, these include: - proactively providing recreation/extra (health visitor/public health nursing) home visiting (Browne et al 1999); parenting programmes to increase social networks, improving relationships in the family system, family problem solving and parental effectiveness (Cunningham et al 1995); promoting a positive school milieu and ethos (Rutter et al 1979) social skills/nurture groups in schools and family centres (Cunningham et al 1995, Place et al 2002). A range of such interventions are being developed in communities and localities and in some cases are being augmented through Sure Start programmes. Many of the preventive initiatives (exemplified above) reflect the creative efforts of practitioners responding to their own interpretations of local need (Offord 1996).

This thesis explores how useful a diverse literature source and nursing knowledge (discussed in chapter five) derived from both experiential and scientific sources is, when applied to the actual experiences within the community context of the parents in the theoretical sample used for the thesis. It therefore provides an opportunity to examine the area of efficacy of research findings and effectiveness in a particular community setting. This focus is particularly important in community CAMH nursing, which involves supporting parents to engage as partners in therapy within a local context. This may differ significantly from the nursing practice context.

The Provision of 24 hour Care

Another important aspect of the complexity of lived experiences of caregivers in the 24 hour context is that there is very little research, evidence or theorisation on the 24 hour care of children with CAMH problems. In common with other areas of health service provision (DoH 2005), CAMH services are beginning to identify a gap between efficacy in time limited experimental conditions and effectiveness in daily living across the 24 hour life space, as discussed by Hoagwood et al 1991.

The research of Henggeler et al (1995) indicates that greater effectiveness in the practice setting can be achieved by services moving from clinical environments to the clients' community and focusing on the total set of extant systems with which the client and family are involved. In terms of the evidence base, Henggeler's work is highly rated, for instance, it is quoted in the Cochrane Review (Woolfenden et al. 2004) as one of the few well-designed Randomised Controlled Trial studies in CAMH and Henggeler et al's multisystemic therapy is arguably the most promising intervention for offenders" (Fonagy et al 2002, p.161). Although this thesis focuses on challenging behaviours arising from disruptive behaviour problems and disorders, the work of Henggeler et al (1995) can be considered applicable to the parents and children in this study because juvenile delinquency represents the extreme end of challenging behaviours and disruptive behaviour disorders and the risks of developing delinquency increase with untreated behaviour problems (Offord et al 1992).

The key to interventions in MST is the family focus with an overriding goal to provide parents with the skills and resources needed to address the challenges of caring for adolescents and to empower the adolescent to cope with problems both within the family and in other systems with which they interact e.g. school, peers, youth clubs etc. A particular focus is devoted to strengthening the extant systems in which the adolescent resides and interacts. The application of research on risk and protective factors (discussed earlier) is central to this approach, "Specific attention is made to strengthening the various systems and an attempt is made to promote responsible and appropriate behaviour among all family members" (Fonagy et al 2002, p.162). However, there is no critical analysis of what "appropriate and responsible" means and by whom it is considered appropriate and responsible within the literature.

Henggeler et al (1998) argue that although MST includes a number of techniques from a range of approaches, it is far more than a mere amalgamation and the focus on the interrelationships between systems is retained. Interventions are individualised and highly flexible but the outcomes are documented in weekly treatment manuals. Treatment fidelity is ensured through weekly group and individual supervision. The entire team reviews goals weekly to ensure a multi-systemic focus. The therapy is delivered by a therapist educated to Masters Level with a caseload of four to eight families. The therapist is available to the family 24 hours a day, seven days a week, but input is adjusted according to need. Treatment usually lasts 3-5 months' (Henggeler et al 1998).

This is a highly intensive programme that requires a total system change in service provision. The context of UK provision and particularly that used in this thesis do not lend themselves to this low caseload and 24 hour accessible provision. However, there have been a number of trials to evaluate the success of MST (Henggeler et al 1996; Henggeler et al 1992; Henggeler et al 1993; Henggeler et al 1986) and these are discussed below.

Henggeler et al (1986) evaluated the effectiveness of MST with juvenile offenders who were repeat offenders ($n = 57$) and compared these with an alternative service provision ($n = 23$). They found that there were significant differences in the decrease in associations with deviant peers and an observed difference in positive family interactions in the MST treated group. In a later study Henggeler et al (1992) randomised a sample of 84 chronic offenders to MST treatment or usual treatment. Costs for the MST group were \$2,800 compared with \$16,000 in the control group. This was mainly because youth in MST were less likely to be arrested or incarcerated and had lower costs associated with the justice system. In a two and a half year follow up, the MST group had fewer arrests than the control group. Thus the treatment was more cost and therapeutically effective. A particular effect of the MST is the low drop out rate (Henggeler et al 1996). Although MST has major strengths, a number of challenges remain.

“The combination of techniques required for effective practice has not been made clear. It is not clear which techniques are essential and which are optional, or how the therapists may choose between the options” (Fonagy et al 2002). These are highly complex practitioner decisions. As Fonagy et al (2002, p.162) point out “There is no

unequivocal algorithm for the dosage required for the treatment to be clinically effective". The search for an algorithm characteristic of medical care fails to take into account the complexity of the practice situation and the complex decision making processes involved in interaction with clients. Further exploration of these decision making processes and their acceptability to service users is required if the work of Henggeler and his colleagues is to be transferred into everyday clinical settings.

A further challenge facing MST is that the treatment programme has not been shown to be effective by workers not involved in its development. Henggeler et al (1997) and Fonagy et al (2002) argue that training in MST is therefore crucial. Training in MST costs about £10,000. This expensive, expert training could be argued to increase the power base of MST while downplaying the impact of 24 hour care.

Although the literature and articles by Henggeler (discussed above) describe the manual used with his intervention group and the process of supervision, his work does not describe how the flexibility and individualised approach is achieved in the actual practice situation.

Instead Henggeler et al's (1995, 1996, and 1997) approach, like that of Cunningham et al (1995) and Webster Stratton (1998) use a manualised approach which has been devised by experts. Cunningham (1995) and Webster Stratton (1998) use methods which have the potential impact of reducing risks and promoting protective factors, but unlike Henggeler they do not explicitly share the language and literature on risks and resilience with clients. The principles used in the Cunningham et al's approach (1995) have been discussed above and are similar in content to Webster-Stratton

(1998) and thus do not incorporate the research in risk and resilience in any explicit way with the parents.

Henggeler et al's (1995) work provides a good example of how evidence based medicine is beginning to tackle some of the issues related to providing 24 hour care and to respond to the gap between effectiveness in actual practice situations and efficacy in research controlled situations. However, evidence based medicine could still be argued to focus on the "primacy of theory" (Richardson et al 2004, p.203) whereas Richardson et al (2004, p.203) and Gustavsson (2005, p. 55) emphasise the "primacy of practice". Richardson et al 2004 argue for:

"... the importance of challenging traditional views that the written word is comprehensively more important and valid than the spoken word, when it comes to claims of knowledge. In this regard, evidence based medicine becomes paradoxical. It developed with the aims of reinforcing practitioners' work and enhancing the quality of health care with the best available knowledge to inform their practices. However, in some cases it can have the opposite effect and has instead silenced practitioners and weakened the legitimate contribution of their clinical skills and practice knowledge to their practice" (Richardson et al 2004, p. 203).

In practitioner research, it is therefore assumed that practice knowledge is derived from a range of knowledge bases, and includes experiential knowledge, which is gained by human experiences, some of which cannot be reduced to scientific or deductive knowledge (Gustavsson 2004). This may be particularly so for most of the daily minute to minute decisions about unique cases or the 24 hour care that is provided by carers for their individual child's needs. The development of practice and services through practitioner research provides a real challenge to the

investigation of and articulation of practice such as CAMH, where there is high need, finite resources and therefore a need to maximise all resources.

As a result of the methods they used, neither Henggeler et al (1995), Webster-Stratton (1998) nor Cunningham et al (1995) discuss the contribution from carers' practice to health outcomes for the children in their studies, despite the evidence of the impact of carer characteristics on risk and resilience factors (Place et 2002, Offord et al 1992), described above. This means that the active involvement of parents through their own knowledge and learning of parents and their ability to alter the risk and resilience profile of their children is not evaluated. Instead the research is evaluated from a rigorous positivist Randomised Controlled Trial perspective in which the carers' views on the care and experiences of receiving the care are not reported and the outcomes are evaluated in terms of predetermined criteria. It could be hypothesised therefore that whilst Henggeler et al (1995) approach increases capacity by providing care which is therapeutically effective and cost effective, it may not optimise the total capacity of the system, because it does not include carers as co-creators of knowledge. This means that carers are supported by experts with a master's qualification, but carers do contribute to the development of the manualised treatment approach nor influence the literature on acceptable approaches to intervention and prevention.

In designing the research reported in this thesis, all of Henggeler et al's (1995) findings were taken into account and shared with the parents who participated in the study. In addition, the thesis explores how support for parents can be provided in an emancipatory way with parents, in order to test out whether the parents can increase

their capacity and that of other professionals through a reciprocal exchange of information rather than an expert dialogue.

Nursing empowerment and 24 hour care

Working to achieve change, emancipation and the critical application of a range of perspectives is compatible with practitioner research, particularly in nursing (Rolfe 1998b; Fontana 2004; Falk- Rafael 2005). This will be explored in more depth in the methodology chapter (Chapter 3). Nursing practice is inextricably linked to care which is viewed as both a universal human practice (Burnard 1997, Morse et al 1991) and as the identified focus for nursing practice (Watson 1985, Leininger 1988, Benner and Wrubel 1989). There is a limited but growing literature on the link between lay (family) care and nursing care. The work of James (1992) and Graham (1984) has identified the 24 hour on-going responsibility associated with family care. Nurses are frequently distinguished by their 24 hour commitment to patients (Audit Commission 1991, Pearson 1988, Kitson 1987, Benner and Wrubel 1989). Kitson (1987) in a comparative analysis of family and nursing care suggests that they seem to be inextricably bound together in terms of concepts shared and activities performed, including commitment, knowledge and skills and respect for persons. She suggests that what differentiates family care from professional (nursing) care is the fact that professional care provides those aspects of care which the lay carer (or family) cannot provide because of a lack of commitment, resources, knowledge and skills. Again this emphasises a deficit model of caring.

Further distinctions between family care and professional care have been identified. Benner and Wrubel (1989) identify the interpretation of the situation which is unique

and memorable for the patient and family but often routine and familiar for the nurse. The role of personal concern can be a great strength and motivating factor in family care, but can cloud judgement when dealing with the unknown or emotionally challenging. The differing time frames for caring activities family care is on-going while nursing care is temporal and limited. The knowledge of caring built up through repeated exposure to similar caring situations which nurses acquire by virtue of their role but which family carers most often experience as a unique case.

The differing knowledge acquired by family carers and nurses as a result of their different experiences of caring have been explored by Callery (1997) who describes the difficulties experienced by mothers of sick children in conveying their concerns about their children to health care practitioners. He identifies that the language used by mothers to describe their concerns evolves from private and intimate experiences and the expression of concerns using this language are not recognised as important by professionals trained to communicate using a scientific non-personalised language. Callery's work highlights the importance of reciprocity when communicating with parents. His work suggests that despite their different use of language, the mothers of sick children have an important contribution to make to the well-being of their child. Opportunities for maximising the child's well-being are lost if professionals are unable to understand and make sense of the mothers contribution to care.

The emphasis on 24 hour care in the nursing literature has given rise to a holistic perspective which is particularly important for nurses, where health has been described in a variety of ways including "met needs" (Abdellah 1960, p.51), "adaptations", (Roy 1984, p.150), "dynamic stability" (Johnson 1980, p.76), "a

process of growth and becoming" (Parse 1981, p.102), "being whole" (Orem 1985, p.26) and "maximising development of one's potential" (King 1981, p.48). Jones and Meleis (1993) propose an additional model for health: health as empowerment. In this model health "is being empowered to define, seek and find conditions, resources and processes to be an effective agent in meeting the significant needs perceived by individuals" (Jones and Meleis 1993, p.61). Much of the literature on caring in nursing remains at an abstract theoretical level. There does not seem to have been much work with parents undertaken in CAMH nursing using holistic and empowering models. One exception is Rindner (2004) who used a Freirean model of empowerment for health education with adolescents in CAMH settings in the United States. Rindner (2004) demonstrated how nurses can support adolescent autonomy and facilitate self and collective learning through group processes, peer teaching and the development of critical thinking skills. Findings from Rindner's study demonstrated that adolescents in primary, secondary and tertiary psychiatric settings could identify their health needs, make choices and take action to achieve those choices, by using the Paulo Freire (1994) empowerment model. Although it is acknowledged that adolescents are in a state of developmental transition and this developmental crisis may lead them to be more open to this empowerment approach than vulnerable parents in the community, the work indicates that an empowerment model may be an effective way of working with this disadvantaged group. However, for the effectiveness of this approach to be tested, the practices associated with this way of working need to be developed and implemented.

Rindner (2004) used the Freire (1994) three stage empowerment model to engage adolescents in the health education process to identify their needs, make choices and

to take action to achieve them. Rindner (2004) discussed how “the nurse educator wants to help the adolescent to shift his/her perception from being an oppressed student to being an empowered student” (Rindner 2004, p.537). Rindner acknowledged the complexity of working in this empowered way e.g. working with adolescents in a psychiatric setting can be challenging because of their developmental needs and also because sometimes the adolescent did not actually wish to be in that setting. In Rindner’s (2004) study, the adolescents were engaged in the empowerment practices through health education. In this thesis the parents are engaged through the group and access to professional knowledge and are also given a voice to influence and refine that set of knowledge and skills.

Developing a Collaborative Knowledge Base in CAMH

In a context of high-identified CAMH need and finite resources, which is characteristic of western publicly funded CAMH services, there is a requirement to optimise CAMH knowledge, skills and resources (Offord et al 1998). Literature from psychology and psychiatry forms the main body of knowledge underpinning CAMH practice as this chapter has demonstrated, and this is used to inform service delivery and the allocation of resources to children and families. Thus, professionals whose skills are mainly focused on the use of “discrete therapeutic episodes” (Procter 2000) currently dominate the generation of CAMH knowledge and practice skills and the allocation of resources. The experience and therefore the skills and knowledge required for discrete episodes of care (Procter 2000) contrasts with carers such as nurses or parents, who require the expertise to solve complex problems arising from caring for children with CAMH problems within and throughout their 24 hour total life space (Redl and Wineman 1952; Croom 1996).

Furthermore, the knowledge and skills from psychology and psychiatry are often derived from randomised control trials in which there is a systematic attempt to rigorously control for all intervening variables. However, the reality of everyday experience across the 24 hour life space demands that carers such as nurses and parents must cope with the total set of events throughout a 24 hour period, which can be simultaneously influenced by individual, social, temporal and cultural variation. As Miller and Crabtree (2000, p. 612) propose “qualitative researchers recognise that the therapeutic or healing process occurs not only in the clinical moment, but also in the everyday life between clinical events. Thus the study of everyday life offers additional perspectives”. It is increasingly recognised that developing effectiveness in actual practice as opposed to efficacy in experimental conditions is a critical issue if the CAMH population needs are to be met (Henggeler et al 1995).

For instance, Bertolino and O'Hanlon (2002:1) discuss the importance of working with clients to develop a “collaborative competency based approach to counselling and therapy”. Although the work of Bertolino and O'Hanlon (2002, p.12) emphasises the critical value and importance of collaborative work with clients, they did not engage in participative research with the clients and the knowledge base derived from their research is predominantly written up in books and articles which are directed at “therapists” and “counsellors”, rather than clients. Furthermore, although they focus on how clients can use their strengths and past experiences to solve current problems and develop solutions, which can create a new “narrative” or life script, they report on the “therapeutic process” involved rather than attempting to explicate and disseminate a cumulative body of knowledge with clients, which arises from participatively

seeking solutions in their practice context (Bertolino & O'Hanlon 2002, p.2). This can mean that the professionals become more skilled in the therapeutic process, but the knowledge and skills of the clients is not necessarily disseminated into a mainstream body of published knowledge.

The dominant paradigm in CAMH can thus be argued to be to one, where professionals are the experts and purveyors of knowledge, who will at best share knowledge they judge to be appropriate with parents/clients or will acknowledge a process which enables professionals to work in a collaborative way with clients. However, they do not proactively seek to explicate or disseminate specialist practice knowledge derived from the clients' own experiences. This situation can potentially exclude parents/clients from both influencing and optimally contributing to service provision creating a gap between the current evidence base and the knowledge and skills required by parents to manage care of children with behavioural problems over the 24 hour period.

Programmes such as Henggeler et al (1995) which attempt to individualise 24 hour care do use a risk and resilience framework. However, it is not known how sharing risk and resilience literature with parents can help them to challenge their assumptions. Brief solution focused therapy focuses on competence and the development of a sense of competence and could be argued to be the essence of emancipatory practice. However, reported studies (Bertolino and O'Hanlon 2002) of brief solution focused therapies tend not to specifically use a risk and resilience framework and therefore have not been able to link this framework to emancipatory ways of working in practice.

There is little research, which explores how the risk and protective factor profile of parents can influence the parent's capacity to utilise knowledge in an optimum way. Knowledge about how the risk and protective profile of the parents influences their capacity to utilise CAMH knowledge and whether access to the CAMH knowledge can have any influence on their risk/protective factor profile has yet to be ascertained. The risk and protective factor profile could be seen as a potential indicator of the parent's capacity to respond to their children.

This is reinforced in a recent study carried out by Ghate and Hazel (2004), on behalf of the National Policy Research Bureau. This was a national study conducted with parents who were randomly sampled on the basis of scores of a deprivation index. The study used both a survey of 10,500 parents of children across Great Britain and also a qualitative in-depth study of 40 follow up interviews with parents in a range of difficult circumstances.

The aim of the study was to provide insights from the perspectives of parents themselves into the world of parenting in impoverished circumstances. The Ghate and Hazel (2004) study explored the stresses, which families face at an individual, family and neighbourhood level; how these stresses impact upon coping with parenting; what supports are available to parents both within and outside their personal networks; what parents want from services and suggests ways in which professionals can improve the planning and delivery of those services. Using this approach, poverty was found to be the most common stressor in the lives of the parents in the study, underlying many of the compound stressors at the individual, family and

neighbourhood level e.g. poor housing, local crime and anti-social behaviour.

However, statistical analysis also identified that having a “difficult child” (scoring high on the strength and difficulties questionnaire Goodman 1999) was identified as one of the highest factors contributing to whether a parent felt that they were “coping” or “not coping”. Having a high number of personal problems, a high malaise score, being a lone parent were also associated with coping less well. The effects on the most vulnerable parents were multiple, overlapping and cumulative. The Ghates and Hazel (2004) study provides further support for the theoretical sampling strategy used in this thesis and discussed in Chapter Four, which focuses on disadvantaged parents, whose children are perceived to be difficult to such an extent that it causes the child and family significant daily distress.

The Ghates and Hazel (2004) study also acknowledged the power of knowledge and found that “Parents expressed a strong demand for more information about parenting and child care issues, 25% wanted to know more about how to deal with children's behaviour and about 20% wanted more information on discipline. In terms of difficult behaviour, about 46% felt that they would like a leaflet; about 28% said they would like a video and about 25% said they would like discussion groups as a preference. However, there is little research and dissemination around how these videos and leaflets should be produced. The Ghates and Hazel study indicates that there may be a significant proportion of vulnerable parents, who would not choose a group as a preference, but would like some written and video material that they can self administer. However, little work has been done with parents to discover the flexible menu of services that they would find helpful or the kind of information, which

parents would find useful in supporting them to deliver 24 hour care tot heir frequently behaviourally challenging children.

Despite increasing recognition of the importance of both gaining knowledge about managing children in the 24 hour context and transferring existing knowledge to those tasked with this responsibility, there is very little participative work with parents or indeed with carers such as nurses or teachers, who care for children with challenging behaviours during significant periods of their 24 hour life space. However, there is a wealth of research, which uses experimental methods such as the randomised control trial and empirical-analytical approaches which attempt to standardise and demarcate effective interventions to support people caring for children in these situations.

Although research, such as the work of Ghate and Hazel (2004) has been carried out with vulnerable parents, little research has been conducted which involves action research as a way of engaging in participative research with parents whose children have challenging behaviours, nor indeed with significant carers of these children such as nurses and teachers, who care for children with challenging behaviours through prolonged periods of the child's 24 hour space. Action research provides a potential way forward for the practice research in this area. It aims to empower and improve the care given by parents and professional carers such as nurses through a reciprocal access to each others knowledge and experiences in order to develop and improve knowledge and practice. Action research is seldom used in CAMH research, particularly when engaging in research, such as in this thesis, in which the researcher has a multiple role i.e. in providing both research and service in the pursuit of practice development.

The multiple role of the researcher has been explored by Seymour and Davies (2002) who are academics, who have been involved in the planning and development of services for child abuse investigations and therapy, including the development of multi-agency centres and education programmes for court programmes. They identify that their roles involve research, programme evaluation, group facilitation, advocacy and planning. To do this they have chosen action research as a way of allowing for the multiple roles demanded of the researcher, when engaged in the facilitation of change. Although Seymour and Davis focus on child protection issues, they are not actually involved as practitioners. However the work of Seymour and Davies can help to illustrate the opportunities of using action research when engaged in practice development. Seymour and Davies propose that “the more common approaches of scientific enquiry and programme evaluation assume a one way influence of science on practice, which may partially account for the low rates of initialisation of research knowledge and low participation in research by practitioners”. This is exemplified in CAMH by the emphasis placed on evidence derived using experimental methods such as the randomised control trial. Their concern with experimental approaches is that it is “about people” and not “for them.” Seymour and Davies discuss their search for a model of research that has “a positive advantage to both the subjects of the research and also those engaged in the attempt to improve the service delivery to vulnerable groups. They feel that action research meets these criteria because it allows for the collaboration of researchers, service providers and clients in the analysis of a social problem and also allows for the multiple roles of a researcher who also has an interest in social change (Seymour and Davies 2002).

Seymour and Davies used action research with practitioners and service users to make practice and education recommendations for improving services in the child abuse arena, but they did not engage in the research as practitioners. Seymour and Davies (2002) acknowledge that the disadvantage of the action research model when involved with clinical services is “the demand for multiple roles that become at times difficult to manage and that can result in a loss of perspective. The researchers can become over committed to anticipate outcomes and consequently disappointed at the reality of what can be done if that reality falls short of the ideals, often as a result of funding shortages and the inertia of bureaucrats.” (Seymour and Davies 2002).

Seymour and Davies (2002) thus acknowledge the difficulties of engaging in multiple roles while undertaking action research. Within practitioner research, this potentially adds one extra layer of complexity, but as a practitioner is steeped in the reality of practice, it may also provide a way of ensuring the development of an action plan that is feasible and sustainable in actual practice situations.

Summary of literature chapter

An exploration of the research and evidence base has highlighted that there are high CAMH needs and finite resources to respond to them (Offord et al 1998). A range of research literature has highlighted the burden of CAMH problems at an individual, fiscal and societal level and identified the need to develop innovative ways of increasing the capacity to respond to children with behaviour problems and their families, by developing an optimum combination of universal, targeted and specialist services (Offord et al 1998, Knapp et al 1999). A range of policy initiatives “Together We Stand” (Health Advisory Service 1995), “Bright Futures (Audit Commission 1999), “Every Child Matters (DfES 2003) and the National Service Framework for

Children, Young People and Maternity services: Standard 9 (Department of Health and DfES 2004) have highlighted the need to optimise all current resources by working with strengths and competencies at the level of the child, the family and the community. Although these reports refer to the need to consult with users and carers, the reports do not identify any specific strategies or methodology to facilitate parent involvement in research, which could ensure that carers such as parents become creators and not just users of services. When parents have been consulted, they have been mainly involved in survey type approaches such as that of Ghate and Hazel (2004) rather than participative action research, which explore how they as carers can contribute to and improve services.

Many nurse researchers (Rolfe 1998a and 1998b, Meyer 2000 and 2001, Titchen and McGinley 2003, Titchen and Binnie 1993) have been involved in participative action research, with the aim of changing and improving services, but much of this research has predominantly been undertaken in collaboration between nurse academics and nurse practitioners and other service providers (Bryar 2003, McCormack 2003 Meyer 2000), rather than in collaboration with clients/carers, as in this thesis. Action research based on a collaboration between academics and practitioners runs the risk of producing knowledge suitable for publication in academic journals but not sustainable in practice settings (Reed 2004). Moreover, it could be criticised for attempting to improve the nursing service from the point of view of nurses rather than clients. If nurses do not progress to carrying out action research in collaboration with clients, they could be criticised for failing to give clients/carers a voice, which may unwittingly develop a nursing hegemony on caring, that is equally oppressive to

families as the empirical-analytical approach currently used to inform the practice evidence base.

The analysis and critique of the CAMH literature given in this chapter highlights a number of gaps between the available evidence and the services provided. Firstly, there appears to be a practice theory gap in discovering how useful the current plethora of CAMH literature on coping with behaviour problems, derived from an empirical-analytical approach under experimental conditions, is to parents when providing 24 hour care to children with behaviour problems in their community context, which is characterised by unpredictability, variability and uncertainty.

A second practice theory gap relates to how much the expertise developed by parents as carers can contribute to building a cumulative body of knowledge on effective responses to children with challenging behaviours. Critiques of the current evidence base in CAMH by writers such as Henggeler et al (1995) highlights the gap between research which shows efficacy in experimental conditions, but which does not translate to effectiveness in community settings. Other research such as that of Hoagwood et al (2001) demonstrates that the link between research done in experimental conditions and the conditions of everyday practice is weak.

Henggeler et al. (1995) describe the need to find a way of bridging this gap by taking an individualised approach with families in which the individual profile of risk and protective factors of the family and their extant systems are identified and responded to in a range of innovative and flexible ways, according to the family needs and preferences and the availability of resources locally. The work of Ghate and Hazel

(2004) emphasises the need to focus on parental competence and to recognise parental stressors at an individual, family and community level. As nurses offer 24 hour care, this thesis explores whether nursing knowledge, derived from both experiential and literature sources in a residential setting (summarised in chapter 5) is useful to parents in a community setting.

A third practice gap relates to how to work collaboratively with parents as research partners within a provider system where the professionals are ascribed the power to generate and determine access to knowledge and services. Although there is a substantial evidence base on the effectiveness of using manuals of parenting training for parents of children with behaviour problems, these manuals are written by experts and the very emphasis on “training” implies that the experts have the power to determine appropriate parenting behaviours.

A further practice theory gap identified through the critical analysis of the literature given in this chapter, is therefore how to produce emancipatory knowledge related to working with children with challenging behaviours in which the parents gain more control of their lives and professionals gain a better insight into how to work with parents in an anti-oppressive way by developing an insight into the opportunities and parameters of knowledge utilisation in a range of contexts in the community.

The practice gaps listed above are derived from a theoretical analysis and critique of the CAMH evidence base as set out in this chapter. The theorisation of this literature created the intellectual framework for the design of the intervention used in this study. Through the process of theorising the gaps between the current evidence base in

CAMH and contemporary CAMH practice, the need to use research methods that enabled collaboration with parents as co- researchers to continue to build a cumulative body of practice and knowledge which is useful in managing children with behaviour problems in the 24 hour space and in formulating practice change, was identified. The thesis will attempt to bridge the practice theory gaps through the inductive analysis of the nursing propositions (discussed in chapter five see Box 4, page 219) with the parents using an emancipatory participatory action research approach. This will be discussed further in the next chapter.

Chapter 3 Rationale for Methodology

Introduction

Essential to any nursing research process is the relevance of the research questions to nursing theory and practice and the methodological assumptions that underpin the study. This chapter sets out the theoretical rationale for the methodology used in this thesis. The thesis takes a practitioner research perspective. Titchen and Higgs (2001) related nursing practice knowledge to professional artistry in which the nurse blends propositional knowledge generated through research and scholarship, personal knowledge generated through life experiences and professional craft knowledge generated through professional experiences in order to create the right blend or pattern for achieving person centred care which is applied in each unique interaction with the patient or client. Titchen and McGinley (2004) described how practising this artistry in which the different types of knowledge are blended, can “lead to health and social care which are both evidence based and person centred” (Titchen and McGinley 2004, p. 122). The previous chapter identified a series of practice gaps derived from a critical theoretical analysis of the evidence used to inform CAMH practice. These gaps give rise to the following research questions:

- (1) Can the nursing knowledge and skills derived from a diverse range of literature and nursing experiential sources, as identified in the nursing project (Croom 1996 and discussed in detail in chapter five) be useful to parents in their 24 hour context in the community, when caring for their child with behavioural problems?

- (2) Can parents in a community setting refine and develop the nursing knowledge and skills (Croom 1996) and so add to a cumulative body of practice knowledge and skills related to the 24-hour management of children with behavioural problems?
- (3) Can parents increase their potential capacity to respond effectively to their children with behaviour problems by gaining access to a diverse body of knowledge and by being participant researchers in the knowledge production process?
- (4) Could service planners and providers utilise parental knowledge, expertise and insight into caring for children with behavioural problems throughout their 24 hour life span, to inform how they could increase the total systemic capacity to respond more appropriately and effectively to the needs of these children?

This thesis explores the capacity for practice change that can be achieved through collaborative work with parents. The thesis also explores how to develop cumulative practice knowledge in which clients (in this thesis parents) become creators and not just users of services. This contrasts with the work of Titchen and McGinley (2004), which focused on research done with fellow nurses to develop practice knowledge. In attempting to develop the autonomy and capacity of the parents, the thesis has to take an emancipatory approach in which there is a critique of the socially imposed constraints that may constrain parents as clients from optimising their capacity. In order to respond to the research questions, an integration of knowledge sources is required, as demonstrated in chapter two. This chapter critically reviews a range of

different methodologies which have been developed in order to inform practice knowledge. These include the Randomised Controlled Trial (RCT), Practitioner Research, Action Science, Action Research and participative action research and critical Social Theory. All of these approaches have practice “improvement” in some form or other as their primary focus. The strengths and limitations of each of these approaches are considered in this chapter. In undertaking this practice based research, it is recognised that all of these approaches influenced the methods used in this thesis to some degree and that in reality the research navigated a course through these methods rather than adopting one and excluding others.

Combining elements of different approaches lead to concerns about method slurring but as this Chapter demonstrates, there is considerable overlap between each of these approaches and as yet, apart from the Randomised Controlled Trial which wasn’t used (although its influence was felt in the knowledge drawn on to inform practice) no agreed definitions have emerged for any of these approaches, making methodological purity difficult to attain in this area. All of these methods are concerned with the development of practice knowledge and practice improvement and so the Chapter begins with a discussion of improvement as it is understood in health sciences where the central concern is to promote clinical effectiveness.

Research in the clinical setting

This thesis engages in participative clinical practitioner research between nurses and parents, who are also clients. This Chapter will debate the methodological issues arising from using this approach. It is recognised that considerable sociological

research has been undertaken with service users (May 1993). Heyman (1995) for instance has undertaken extensive research into the user perspective on health care, often comparing user perspectives with professional perspectives on health, illness and disability. In his work each perspective is seen as equally valid, but fundamentally different. However, clinical research is about effectiveness and not perspective (Muir Gray 1997, Fulop et al 2001). It strives to find out what works clinically for patients. As a consequence much health services research is dominated by the Randomised Controlled Trial which heads up the hierarchy of evidence used to evaluate clinical research (Muir Gray 1997, Rolfe 1998a and 1998b) and is often depicted as the gold standard for developing clinical guidelines (Centre for Reviews and Dissemination 2001). While the Randomised Controlled Trial identifies what works in practice, as this chapter will demonstrate, it is pre-disposed to adopting a professional perspective and so excludes the user perspective and the potential contribution this could make to the development of knowledge on clinical effectiveness. There is, therefore, a paucity of clinical research that has been done *in participation* with clients, using qualitative methods to address clinical effectiveness. This is particularly the case in the field of CAMH, where, as discussed in the Literature Chapter, the main body of evidence used to inform practice is derived from a quantitative perspective (e.g. Woolfenden et al 2004), dominated by the Randomised Controlled Trial methodology.

Schein (1987, 2001) has worked as a clinical researcher involved in organisational systems research. He contrasts the assumptions and methodologies of the clinical perspective with other approaches to data gathering, particularly the ethnography approach. He proposes that “these assumptions have far reaching consequence for the

investigator's moment to moment behaviour and for the kind of data revealed” (Schein 1987: 11). In contrast to experimental researchers, both ethnographic and clinical researchers using case study and qualitative methods work “in the field” as opposed to setting up controlled experimental conditions. However, Schein (1987, 2001) proposes that there are key differences between ethnographic and clinical research, which must be acknowledged. He states:

"The formally educated clinician is trained to think in terms of protecting the client from unscrupulous, wasteful or harmful treatments, and is made aware of the necessity to create a supportive environmentand to enhance the client's ability to learn to continue to solve his or her own problems. Part of being truly professional in this context is to avoid creating too much dependency on the part of the client.the professional ethics of the ethnographer have much more to do with obtaining valid information without influencing or disturbing the system being studied any more than is necessary.... Typically the ultimate goal is to obtain valid data for “science”, not to change, help or in other ways influence the system" (Schein 1987, pp.20-22).

According to Schein's (1987) rather idealised interpretation of the clinical role, the clinician typically starts with an action research model as defined by the likes of Agyris, Putnam and Smith (1985). A defining feature of action research is the concept of change (Meyer 2001, Waterman et al 1995, 2001). The ethnographer on the other hand takes a more descriptive analysis to obtain an objective understanding of the situation/organisation without changing it. This thesis takes the clinical approach advocated by Schein (1987) in which participatory action research is used to undertake an inductive analysis with parents of the nursing knowledge framework

(Appendix 2) derived from previous participative clinical research with fellow nurses (Croom 1996) in order to produce emancipatory practice knowledge and skills.

Access to and critical analysis of this nursing framework became part of the intervention with the clients (parents in this thesis) and also part of the emancipatory change process.

Schein (1987: 42) describes how the clinical and ethnographic perspective “lead to different levels of knowledge, but the clinical knowledge is often “under-utilised and under-credited because it is not gathered by traditional models of scientific enquiry”. For clinicians, the situation is more complicated because one of the assumptions clinicians make is that their very presence changes the situation, and in fact, change is one of the reasons for being present. Clinicians thus rely for their “ultimate validation tests ... on... whether they can predict the results of a given intervention” (Schein 1987). This relates to the practitioner research aim of developing interventions/skills” knowledge which work in the practice situation and reflect the “improvement criterion” (Schein 1987, 2001). It must be recognised, however, that Schein worked with fellow professionals in organisations rather than with clients requiring health intervention and in that sense, his work is more closely allied to action research than participative practitioner research.

Randomised Controlled Trials and Practitioner Research

In many ways the Randomised Controlled Trial could be depicted as a primary exemplar of practitioner research because by definition it cannot be carried out in

academic institutions divorced from practice situations and it is fundamentally designed to find out what works using established scientific, experimental methods. However, practitioner researchers adopting qualitative approaches have concerns about the linear “top down” approach used to generalise Randomised Controlled Trial knowledge as described below and are more concerned to develop approaches which enable practitioners to become creators of knowledge through reflecting on and increasing their insight and understanding of their own practice. This recognises, as the following discussion illustrates, the importance of contextualising knowledge to the local situation.

McCormack (2003) proposed that there continues to be a divide in nursing between the “knowledge generators” and the “knowledge users” and that although there has been considerable progress made in the use of practice research, less progress has been made in formally connecting academic and practice communities. McCormack argues that this connection can be achieved through a focus on practitioner research, because this approach links both knowledge generations with knowledge utilisation.

McCormack (2003, p.88) identifies that there is a “traditional divide between researchers (those who strive to “know”) and practitioners (those who “act”)”... which has led to “practitioners viewing researchers as being in an ivory tower because of a perceived hierarchy between the bearers of knowledge and those who need the knowledge to support their practice” ... “which has greatly influenced the development of knowledge in nursing”. However, McCormack does not address the implication of this hierarchy in terms of the development of knowledge for carers, who must work in partnership with nurses. McCormack argues that “health care practice is currently dominated by discussions about the need for evidence-based

practice” in which practitioners “read literature, critically make sense of literature in their own practice context and then change the culture of practice within their sphere of influence”.

In many ways the gap between knowledge producers and knowledge users in nursing research identified by McCormack reflects the wider interpretation placed on the value of evidence and research in the NHS. For instance the DoH guidance on clinical effectiveness (DoH 1995) suggests a framework based on informing, monitoring and changing practice that is informed by a hierarchy of evidence dominated by quantitative studies using experimental methods. Prior to this, the DoH stated:

"Many members of the nursing profession undertake small scale projects which interest them ... however, it must not be seen as a substitute for the generalisable and cumulative research which we would place at the heart of a strategy for advancing research in nursing" (DoH 1993, p.6)

This contrasts sharply with the view of nursing as providing highly individualised care:

"Highly individualised care is considered an indicator of quality nursing care and treating each individual as unique is a cherished value in nursing" Radwin (1995, p.366).

There is, therefore a tension between the ascribed value placed on nursing research, which aims to improve individualised care, carried out by practitioners and the dominant view expressed by the Department of Health, which emphasises the value of

large scale, generalisable research projects, which are carried out by research specialists:

"Research done properly is a highly professional and specialised activity and not suited to every practitioner, but every practitioner needs to be involved in using the results of research" (DoH 1995 p.2)

It could be argued that the DoH view of research based or evidence based practice is elitist and "suggests a hierarchical relationship not only between theoreticians and practitioners, but also between theory and practice, such that research generates knowledge, which builds, supports or tests theories and which in turn determines practice" (Rolfe 1998a, p.180).

If this is the case then "It is the theories of the pure scientists that dictate the action of those in practice, the applied scientist. Though the relationship between theory and practice appears to exist, it seems somewhat unidirectional in nature" (Prymachuk 1996, p. 680). Schon (1983, 1987) referred to this unidirectional, hierarchical relationship as technical rationality which he claims has led to a crisis in confidence in professional knowledge and a growing mistrust by practitioners that academic knowledge can offer anything of relevance to practice situations. "In nursing this crisis in confidence has become known as the theory practice gap" (Rolfe 1998b, p.675).

Experimental quantitative methodologies aim to develop technical knowledge by testing hypotheses, using an emperico-analytical perspective, which attempts to

control for any intervening variables that may confound the relationship between the chosen variables. This has limitations when attempting to achieve the practice research aims of this study because:

- (a) It is extremely difficult in the everyday context of practice reality to control for all of the potentially confounding variables. In attempting to control for the wide range of variables, which exist in everyday life, any outcomes will potentially be too reductionist to be useful when applied to the complexity and diversity of everyday life situations of parents.
- (b) Experimental quantitative studies rely on a hypothesis, which is determined by the researcher and thus serves the interest of the researcher and may be of little relevance to the individual parental priorities in a 24 hour setting.
- (c) In attempting to “control” for human elements it is inherently non-participative.

Although logical positivism, experimental research and the laboratory methods have dominated the 20th Century, the approach has been increasingly challenged (Reason and Bradbury 2001). Thomas Kuhn’s (1962) work on the nature of scientific revolution proposed that knowledge comes through shifts in paradigms and conceptual models and illustrated the dynamic tension between science and values. As a result he promoted a view of science as a construction rather than a set of empirical truths. Schon (1987) developed the critique of the traditional scientific paradigm when used in the context of developing professional knowledge. He highlighted the limitations of traditional experimental quantitative research, which he referred to as technical rationalism and argued for the need for a more context specific science. He makes the case for a new paradigm based on practical knowledge where the

practitioner explores the effectiveness of “technical expert” knowledge for problem resolution in the practice situation and for generating new knowledge. Schon (1987) explored the requirements of practice knowledge and raised considerable doubts about the transferability of knowledge produced in decontextualised controlled environments to the complex and unpredictable world of practice. Schon (1987:67) highlighted what he called the “rigor v relevance dilemma” in which both practitioners and researchers face the choice of remaining on the “high ground” to solve problems, which are relatively unimportant in practice according to standards of prevailing rigor or descend to the “swamp” of important practice problems and consequent non rigorous enquiry. Schon (1987) attributed this dilemma to the dominance of the “technical rational model”, exemplified by the quantitative paradigm.

As Schon (1987) recognises, in practitioner research terms, treating the application of the evidence base as a linear process is too simplistic and reductionist. A linear approach fails to take into account the dynamic nature of practice, which requires the need for high external validity in the practice setting in order to answer the question- does it work in actual practice for this client or patient in this situation with this resource available to them and these demands being made upon them or in the context of these co-morbidities.

Additionally a linear approach to the application of evidence in practice such as that advocated by the Department of Health, fails to recognise that knowledge represents power and so can lead to prescribed inequalities between the knowledge used by different professional groups e.g. between psychiatrists/psychologists, whose

professional knowledge base is legitimated by the hierarchy of evidence described earlier, and that of nurses, whose role requires an integration of care and knowledge to meet the individualised needs of the patient (Audit Commission 1991).

As Rolfe (1998a and 1998b) points out, nursing practice requires an eclectic knowledge base to deal with the complexity of integrating and coordinating care. The power gap created by the current emphasis on specialist, generalisable studies is potentially even greater when nurses attempt to cross the professional/client domain and include the knowledge of service users as part of the practice knowledge base because users are even more isolated from access to the production of knowledge than nurses.

McCormack (2003) focuses primarily on practitioner research with fellow nurses rather than between nurses and clients and argues “that there needs to be a more explicit commitment to the connection between academic and service communities”. This thesis goes further than that and argues that parents or service users must be incorporated as part of the practice community because they provide the greatest amount of care in the community. This gives rise to a need to forge a connection between academic research and the client/carer communities. In order to achieve this, the practitioner research methodology must cross the professional carer/client divide.

The overarching theoretical framework used in this thesis recognises the need to adopt a multi-perspective approach which reflects the realities of practice experienced by nurses (Rolfe 2000). This approach acknowledges that there are multiple perspectives/narratives rather than an overarching dominant ideology and that all of

these approaches make a valid contribution to practice knowledge. The concept of realist synthesis is currently being developed by Pawson et al (2004) in recognition of the multiple perspectives that need to be accommodated when developing evidence for practice and practice theory. However, this theoretical practice work is very much in its formative stage and was not available at the start of this thesis to inform the approach taken. It does, however, lend weight to the approach taken here and indicates its currency. In the absence of an established method for integrating the multiple perspectives selected for inclusion in this research, the rationale for the combination of methods used is made transparent through an analysis of their fitness for informing practice. It is acknowledged that this may seem subjective and could introduce bias or selectivity, but it is justified by the pressure to develop practice knowledge. It may be flawed, but it is only through trying and exposing the difficulties and limitations through an honest and transparent account that we can hope for progress. As a nurse researcher, choices must be made about what is considered to best fit the purpose of practice research. The rationale for the combination of perspectives applied must, therefore, be made transparent in order to develop knowledge that is fit for practice, without constantly reinventing practice knowledge. This thesis is attempting to achieve an increased understanding and insight into CAMH practice when providing continuous periods of care for children with behavioural problems by specifically focusing on how nursing knowledge and skills, derived in a residential setting, can be useful to parents in their community; how parents can contribute to the understanding of knowledge needed to provide continuous periods of care for children with challenging behaviour problems/disorders and how incorporating parents as creators and contributors to and not just users of services can increase the total system capacity to respond to children

with behaviour problems within their total life space. The thesis is not attempting to achieve generalisable findings in the quantitative paradigm, nor is it attempting to achieve an objective description of the parent's experiences in the traditional ethnographic paradigm, but it is attempting to change, develop and refine practice by working in a collaborative and emancipatory way with parents. The focus of the research is thus to achieve the aims of practitioner research by exploring how to improve practice in four ways:

1. By exploring knowledge and skills which parents feel are useful in the care of children with challenging behaviours over a 24 hour period in the community i.e. to explore the external validity of the body of CAMH research, derived from mainly Randomised Controlled Trials, which are recognised to have high internal validity and low external validity.
2. By attempting to respond to the high levels of demand for CAMH services within finite resources through exploring how capacity can be improved via the process of refining and developing a cumulative body of knowledge which integrates the evidence based work on challenging behaviours and the experiential knowledge of nurses with the experiential knowledge of parents.
3. By exploring how to develop systemic practice capacity by working with parents to identify how/if they can maximise their capacity to respond to children with behaviour problems by providing them with access to a diverse range of knowledge. Also, to explore how professionals can maximise their capacity through an increasing insight into the parents' experiences and knowledge base and the factors, which can impact on the parents' capacity to optimally implement relevant knowledge and skills.

4. It aims to produce a practice framework, which incorporates the findings from this thesis in order to support parents and professionals in responding to children with challenging behaviours i.e. to enable an action plan to emerge, which is grounded in the thesis findings. The practice framework can thus be a platform for future practice development at an individual, family and community level and for developing this eco-system approach to practice research (Khanlou and Peter 2005).

Types of Knowledge used in Practitioner Research

Elliot (1991) saw the primary aim of practitioner based research as the improvement of practice and argues that the validity of the knowledge and theories it produces depend entirely on their usefulness in helping people to act more intelligently and skilfully. Elliot's definition of practitioner research has great resonance for this thesis which critically explores the extent to which parents and practitioners feel more supported and skilful as a result of the research. However, it is acknowledged in this thesis that

"Social theory is not something that can be separated from the process of social research. Theory informs our thinking which, in turn, assists us in making research decisions and sense of the world around us. Our experience of doing research and its findings, in turn, influences our theorising; there is a constant relationship between social research and social theory" (May 1993, pp.20).

The thesis acknowledges that there is a range of different types of knowledge (Heron 1992, 1996; Heron and Reason 2001). Heron and Reason "call this "extended epistemology"- a theory of how we know, which is extended because it reaches beyond the primarily theoretical knowledge of academia" (Heron and Reason 2001, p.183).

Heron and Reason (2001, p.181) define four ways of knowing:

- Experiential knowing is derived through direct face to face contact with person, place or thing; it emerges through the immediacy of empathy and resonance.
- Presentational knowing emerges from experiential knowing and provides expressive meaning through expressive forms of imagery such as dance or poetry.
- Propositional knowing knows about something through ideas and theories expressed in informative statements.
- Practical knowing knows how to do something and is expressed in a skill, knack or competence.

This thesis aims to explore a combination of these different types of knowing with parents. In so doing it recognises that knowledge can contribute to practice

development in different ways. McLaren (1989, p.167) distinguishes between three types of knowledge that can be produced from participatory research:

- Technical knowledge, which can be measured and quantified. It is based on natural sciences, uses hypothetical- deductive reasoning or empirical analytical methods.
- Practice knowledge aims to enlighten individuals in order that they can shape their daily actions in the world. It is acquired through describing and analysing social situations and is geared towards helping people to understand ongoing social and situational events.
- Emancipatory knowledge attempts to transcend the tension between practical and technical knowledge. It helps to understand how social relationships are distorted and manipulated by relations of power and privilege. Emancipatory knowledge aims to create the situations under which domination and oppression can be overcome and transformed through collective action and creates a foundation/platform for justice, equality and empowerment.

In engaging in research, whilst simultaneously offering a service, this thesis attempts to integrate all of these types of knowledge in a way which improves practice by iteratively developing knowledge and skills, that are pragmatic and emancipatory. The pragmatic focus explores how to increase the capacity to respond to children with challenging behaviours and care for them within their everyday life experiences. The emancipatory focus explores the practitioner knowledge and skills which may be

developed and which could support practitioners to work with carers in ways, which are relevant to the carers' particular context and which support carers to critique the status quo and thus potentially gain more control in their lives by recognising and challenging overt or tacit oppression. This can enable parents to transform their role to creators rather than just users of services.

This thesis must also be considered in the context of knowledge generation in nursing: As Rolfe (1998a) notes "Unlike sociology, nursing is essentially a practice based discipline and the knowledge generated by clinical research must somehow be translated into nursing practice if it is to help us decide, if not how to live, then at least how to nurse" (Rolfe 1998a pp. 85)

Using practitioner research to improve practice requires the synthesis of a range of methods and knowledge. Rather than seeing the different research paradigms and perspectives as oppositional, hierarchical or separate, the need to build bridges between these different theoretical worlds is increasingly being recognised and acknowledged. As Miller and Crabtree (2000) state "The dominant biomedical world and the smaller qualitative research community both tend to maintain methodological and academic rigidity. Creating a clinical research space requires bridging both groups outside of their walls and finding common ground and common language" (Miller and Crabtree 2000, pp. 608). They argue that the dominance of technological advances has occurred because "depth and context have been reduced or eliminated and relationships have been isolated and alienated. At the walls separating clinician from patient, qualitative from quantitative, academy from practice, very different ways or cultures of knowing can meet and converse" (Miller and Crabtree 2000 p.608).

The need to build bridges between different research traditions is also recognised by Taylor (1993). "The clinical questions at the wall are the common ground" ... these questions "call us to rediscover the missing evidence (the people, experiences and contexts) and the richness and depth of what "effectiveness" means" (Miller and Crabtree 2000, p.608). In order to do this "the methods are evolving, beginning to separate from their parent traditions (such as ethnography, phenomenology and grounded theory) and generate new hybrids in the clinical research space" (Miller and Crabtree 2000, p.609). This thesis attempts to create such a hybrid by engaging in a conversation outside the walls of technical knowledge and experiential knowledge (using a practice framework produced by nurses in a residential setting derived from a diverse range of expert literature and experience - discussed in depth in Chapter 5) at a place "where the walls meet clinical reality" (Miller and Crabtree 2000, p.608). It thus provides an opportunity to explore how to align a range of methods in order to answer some key practice questions in CAMH nursing related to how transferable technical and experiential nursing knowledge is to vulnerable parents in their 24 hour context when caring for children with challenging behaviours.

Practitioner research is not neutral and value free. There is a tension between the philosophy of practice research and the generation of practice knowledge to develop and improve individualised care and the philosophy of traditional research, which assumes the need for neutrality in order to produce generalisable knowledge. Rolfe (1998a) argues that "the application of generalisable, research based knowledge to individual, unique, person centred practice, the so called "research based practice" identified by the Department of Health is one of the main causes of the theory-

practice gap). He argues, therefore, that “Nursing requires a paradigm of clinical research which focuses on the individual encounter in order to complement the sociological paradigm of theoretical research, which is best suited to the generation of generalisable knowledge and theory” (Rolfe 1998a, p.85).

In order to explore a way forward, it is argued in this thesis that it is essential to identify whether /to what extent published literature, which produces technical knowledge and provides generalisable findings, can be applied to the lives of carers at an individual, family and community level. Unlike the dominant organisations such as the DoH, which proposes that the Randomised Controlled Trial approach to research is the gold standard, it is argued in this thesis that findings from RCT research should be inductively analysed in practice situations for their relevance in moment to moment everyday contexts in order to establish the external validity of the findings within the context of existing delivery systems. In researching in the “messy world of practice” Schon (1983), makes the case for an iterative approach to knowledge and skills development in which the emerging findings and theory have validity, not through statistical testing but through their capacity to produce practice change and to generate further insights (Maturana 1991). This interpretation of validity informs the methods used throughout this thesis.

Consequently one of the themes explored in this thesis is how to use the findings from Randomised Controlled Trial research, which produces technical knowledge, to inform everyday knowledge in practice. In this case, the findings from Randomised Controlled Trial research were used as a tool with which to iteratively critique and interrogate practice knowledge and assumptions, which otherwise may not be

accessible or appreciated, because the everyday knowledge is intuitive and taken for granted. The use of critique and the recognition of ideological perspectives underpinning knowledge generation during the process of knowledge use (used in this thesis) contrasts sharply with the dominant orthodoxy of linear application through adherence to evidence-based clinical guidelines.

The thesis goes on to consider whether the technical knowledge created from the findings from Randomised Controlled Trial research can be used not to inform practice directly but to raise the awareness, competence and problem solving capacity of professionals and carers within the context of their own experiential knowledge, which can in turn add to the body of knowledge for practice. However, the thesis also acknowledges that there is a further tension between nursing research, which focuses on individualised care and the public health agenda, which attempts to take a population approach. Just focusing on the knowledge used or generated from the individual encounter fails to recognise the multiple co-demands made on carers and therefore creates knowledge which in practice is difficult to transfer (Khanlou and Peters 2005)

In the espoused value of providing an equal access service to all, there is a pragmatic need for all practitioners to increase the capacity to respond effectively in situations of high need and finite resources. This thesis attempts to resolve this tension by making it explicit that it does not aim to generate generalisable research findings, but rather to develop generative findings upon which others can build upon. Findings from individualised care or individual experiences can then be used by other practitioners.

Developing Contextualised Knowledge about Individualised Care

Benner and Wrubel (1989) and Fish and Purr (1991) acknowledged the need for nurses to derive knowledge, which is contextualised in the reality of practice in order to produce findings, which are generative rather than generalisable. Schon (1987) proposed that expert practitioners were those, who could integrate technical knowledge and experiential knowledge at the moment of implementation and identified the process of knowledge attainment through “reflection” in practice as the most effective way to solve complex practice problems. As Higgs et al (2004) point out “... some aspects of practice can never be understood by the tools of empirical science... this is particularly so for most of the daily minute by minute decisions about each unique case” (Higgs et al 2004 p. 63). Polyani (1966) and Schon (1983) used the term *tacit knowledge* to describe knowledge, which they felt was intuitive/unknowable and inexpressible. However, although this thesis acknowledges the difficulties of accessing tacit knowledge, it argues that tacit knowledge is such a crucial aspect of practitioner knowledge, that the assumption that it cannot be accessed and therefore disseminated, potentially leaves practitioners, (particularly practitioners involved in daily minute by minute care such as nurses or parents) in a disempowered position, relative to the traditional scientists, whose knowledge base is informed by prolific amounts of published literature.

This reflects the work of Higgs et al (2004) who suggest “... there remains much of our practice, which can be known and expressed in words, if practitioners and researchers continue to seek to understand practice, find new tools for investigating, describing and measuring it. The use of “tacit” to describe such knowledge is a loose and incorrect use of the word” (Higgs et al 2004, p. 63).

This thesis acknowledges that although there are tensions in deriving knowledge from practice using traditional experimental quantitative methodologies, there are also limitations with qualitative and reflective methods as a basis for knowledge generation to practice. As Doyal (1993) points out reflection “may form part of a self-validating cycle of knowledge generation reinforcing cultural beliefs and stereotypes” (Doyal 1993, p.20). Garfinkel (1967) proposed that the “anthropological strangeness” of traditional social scientists was central to qualitative methodology as it provokes questions about the history, values and beliefs of the culture under study, which are too familiar to the participants to be explicated. This poses difficulties for doing practitioner research, because it is impossible for practitioners who form part of the social world under examination to adopt the naïve stance proposed by Garfinkel, as they will be steeped in their everyday practice assumptions and beliefs, which underpin their tacit knowledge and skill base (Procter 1995). These difficulties with the use of qualitative research methods to produce knowledge which informs clinical effectiveness in practice are still being debated within the methodological literature and are unlikely to be resolved in this thesis. They do, however, create real challenges for nurses using qualitative methods to improve aspects of their practice. Action research is increasingly recognised as a method that has the potential to address some of these dilemmas.

Action Science – A Way Forward

Action science was first proposed by Argyris et al (1985, p.10) as an approach to action research, which can articulate “the features of a science that can generate

knowledge that is useful, valid, descriptive of the world and informative of how we may change it". However, although action science has been cited as one of the most popular "action technologies in use (Raelin 1997), it has also been cited as being difficult to understand and to practice (Edmundson 1996, p. 586; Raelin 1997) It is "difficult to find a single, comprehensive definition of action science in the literature" (Friedman 2001, p.159) although a range have been proposed:

"Action science is an enquiry into social practice, broadly defined, and it is interested in producing knowledge in the service of practice". (Agyris et al 1985, p. 232)

"The action scientist is an interventionist, who seeks both to promote learning in the client system and to contribute to knowledge". (Agyris et Schon 1996, p.36)

"An action scientist would concern himself with situations of uniqueness, uncertainty and instability, which do not lend themselves to the application of theories and techniques that are derived from a science in the mode of technical rationality. The aim of action science is to develop themes from which ... practitioners may construct theories and methods of their own". (Schon 1983, p. 319)

Action science "focuses on creating conditions of collaborative enquiry in which people in organisations function as co- researchers, rather than subjects" (Agyris and Schon 1996, p.50)

Friedman (2001, p.159) integrates this background to define action science as "a form of social practice, which integrates both the production and use of knowledge for

the purpose of promoting learning with and among individuals and systems, whose work is characterised by uniqueness, uncertainty and stability”.

Friedman (2001, p.159) discusses how action science “attempts to bridge the gap between social science and social research by building theories, which explain social phenomena, inform practice and adhere to the fundamental criteria of a science”. The goal of action research is research in practice and not on practice and aims to help practitioners discover the tacit choices they have made about their perception of reality, their goals and ways of achieving them. A fundamental assumption of action science is that it is by explicating these tacit choices, that people can achieve greater control. Action science assumes that human beings are theory builders and construct theories, which they will then test through action.

Agyris et al (1985) propose that the features of positivist science including the requirement for observing causal relations under situations of control, maintaining distance to safeguard objectivity and a focus on means rather than ends produces “theories, which are too complex to be used by practitioners in real time and are difficult to produce in situations where all the variables are changing at once” (Agyris et al 1985, p. 41-43). Action science acknowledges the phenomenological and interactive research methods, which offer a useful approach to practitioners, who require theories that explain problems within the context of particular systems and sets of meaning. However, qualitative methods have so far been unable to produce rationales for agreeing on the validity of the different choices made within a professional or service context. In reality practitioners need to act and action requires

that choices, knowingly or unknowingly, are made from the different interpretations available (Keeley 1984).

Friedman (2001) proposes that the four identifying features of action science are:

- Creating communities of inquiry within communities of practice.
- Building theories in practice
- Combining interpretation with rigorous testing
- Creating alternatives to the status quo and informing change in light of values freely chosen by social actors

These will be now analysed in turn in relation to the application of action science to this thesis.

Creating communities of inquiry within communities of practice.

According to action science, “there need be no division of labour between those who produce the knowledge (the scientists) and those who use it (the practitioners). The role of the researcher is to create conditions under which practitioners (e.g. Teachers, social workers, nurses, doctors) can build and test theories of practice for the purpose of learning”(Friedman 2001, p.160). In this thesis, the researcher was testing out whether access to the nursing knowledge, derived from the previous piece of action research (discussed in chapter 5) carried out by the author with nurses in CAMH, was useful to parents whose children had challenging behaviours and what else the parents

could contribute to nurse practitioner learning in CAMH. Thus in this thesis, the research was contributing to the practice base of nurses as well as that of parents. It had to be acknowledged, however, that there were differences to traditional action science as the researchers/ practitioners were offering a service to the parents. Agyris et al (1985, p.34) called action science the creation of “communities of enquiry in communities of social practice”. They defined a community of practice as teachers, social workers etc. who share a common “language of practice” learned in the course of their education. In this thesis, nurse practitioners were working with parents, with whom they shared a common practice goal of providing and improving 24 hour care for children with challenging behaviours. Developing a common language to understand the commonality and parameters of this experience was part of the action research of this thesis. The “care” language knowledge and skills of both nurses and parents, which the parents’ and nurses’ professional language reciprocally shared and the potential for improving the care provided by both carers and practitioners as a result of this was analysed. The potential impact on the capacity for responding to children with behavioural problems through the action/intervention of mutually sharing information and researching solutions in a collaborative process was explored.

In order to achieve this, the practice researcher in this thesis had to be accountable to produce a group milieu (Crago 2006) in which the parents could feel sufficiently confident to critique the nursing knowledge and create further knowledge whilst also feeling that they were being offered a service, which they perceived was helpful to them. In order to promote this level of critique, both the nurses and parents were supported through the use of critical theory (Fontana 2004), to discover the tacit choices they had made about their perceptions of reality/their practice experiences and

the goals and strategies they used. The critical edge required to interrogate their taken for granted, tacit knowledge was provided by the practice framework initially developed with the nurses (appendix 1) and by exploring the emerging knowledge of both the parents and the practitioner researcher. The parents' experiences thus provided a tool to critically interrogate the nursing practice and the nursing practice framework was used to critically interrogate the parents' experiences. The potential tendency for nurses as professionals to tacitly/unconsciously recreate the status quo and for parents to follow this was critically interrogated through the application of critical theory. The fundamental assumption of action science is that by gaining access to these choices, people can achieve greater control over their fate. (Agyris et al 1985). It is assumed that this enables individuals to produce change. Thus the parents were supported to change their interpretation of their stated problem of having difficulties managing their children with challenging behaviours. By collaboratively developing a community of enquiry within each group used in the research (see Chapter four), the nurse researcher/ practitioner was able to develop practice knowledge on how to support parents by providing access to a wider range of professional knowledge and to test out whether opening up parental choices for action and by learning from parents experiences created increased choice for future nursing action.

Building theories in practice

Action science assumes that human beings are theory builders, who construct theories of reality which they continually test through action (Agyris and Schon 1996;

Friedman and Lipschitz 1992). The objective of action science is to make tacit theories explicit so that they can be critically examined and challenged.

A theory in practice consists of a set of interrelated theories of action for dealing with problems typical to practice situations. The work of action science involves “constructing and testing theories in practice by inquiring into the actor’s behaviour and the reasoning behind it” (Freidman 2001, p.161). Through the groups, the parents were encouraged to explore how they understood the situation with their child, what they want to achieve, ways /strategies for achieving this (including the nursing framework), what happens and the outcomes both personally for the family and in terms of capacity. This was achieved by asking the parents to reflect on actual situations at the beginning of each group session, to explore strategies for resolving any issues, to introduce the parents to the nursing practice framework, to explore if this enabled the parents to consider other alternatives, which the parents would then test out at home and bring back their findings to the following group. This enabled the research to produce detailed context rich theory of the patterns of behaviour and solutions employed, which could be employed or used as a basis for solving future situations.

Combining interpretation with rigorous testing.

Action science attempts to integrate the context rich power of the interpretative approach with the rigorous testing of more positivist science (Agyris et al 1985, p. 54). This approach has areas in common with Popper's (1959) idea of “falsifiability” (Agyris 1993, p.284). It assumes that “all knowledge of reality is

partial and indeterminate". Theories can never be proven but they can be maintained as long as they withstand disconfirmation. Thus action science testing "depends on the participants' willingness and ability to formulate their claims in ways, which leave them open to be wrong" (Agyris 1993, p. 284). This requires practitioners to be "strongly motivated to seek out information that can lead to disconfirmation" (Agyris 1993, p.284). This is an important criterion for practitioners, who are wanting to develop clinically effective practice and who are concerned that they may otherwise attempt to prove themselves right and so stay in control. In this thesis, the parents were supported to engage in a rigorous inductive analysis of the relevance of the nursing framework to their context. They were explicitly encouraged to be honest and to develop their understanding that disconfirming the nursing framework was just as useful as confirming it. Disconfirmation led to discussion within the groups of alternative solutions, which could either lead to modification of the nursing framework (appendix 1) or arise from either literature or from their experiences. These could then be rigorously tested for their practice usefulness as the parents then tried these out in their own homes and reported back the following week.

Creating alternatives to the status quo and informing change in light of values freely chosen by social actors.

Action science explicitly aims to help practitioners to "transform their world" (Agyris et al 1985, p. 71). In contrast to social engineering, which applies scientifically based solutions to particular problems, action science is a form of ongoing "social experimentation" (Schon et al 1984). Action science thus involves an iterative process of learning and movement rather than achieving "stable states" (Schon 1971).

In the thesis, the access of the parents to the nursing framework and other associated professional literature provided an intervention, which was tested out for its relevance to parents using action science. The researcher's access to the parents' experiences, through her practice with the parents as part of the research, provided an intervention which was tested out to explore if this could increase practitioner knowledge. The reciprocal access to the knowledge bases provided new actions in which there was an exploration of the potential for increasing the capacity of the parents and practitioners through their mutual access to each others' experiences and knowledge base. The findings provided a way of developing the original nursing framework and thus providing the basis of action in the future, in order to continue the iterative process in which both nurses and parents can become aware of their tacit knowledge and beliefs and the choices open to them and so develop further opportunities to refine and develop their experiences. In addition the findings can provide a platform from which to further explore how collaborative action research can be carried out with clients whilst simultaneously offering them a service.

However, action science, like action research described in the nursing literature (McCormack 2003, Meyer 2001, Waterman 1995) tends to refer to clients as professional members of organisations rather than the clients (carers) to whom the organisation is offering a service. Action research with parents brings additional complexity, which is specifically related to the potential inequity in power, between the parents and the researchers/providers. The critical debate required to analyse this inequity in power, will be provided by the application of critical theory (see below p124). Thus in seeking to carry out research, whilst offering a service, the thesis must combine action research, critical science and critical theory in a way, which attempts

to integrate the specific “uniqueness, uncertainty and instability” (Schon 1983) inherent in co-researching with parents of children with challenging behaviours, whilst offering them a service.

The objective is to make tacit practice theories used by nurses and parents explicit so that these theories can be critically examined. In this PhD study, action science is used to provide an approach for discovering how parents make sense of their world in order to articulate the knowledge and skills which underpin the solutions, which parents perceive to be effective for and within their everyday context. However, traditional action science does not comprehensively address some fundamental practitioner research issues:

- (1) How to develop a cumulative practice knowledge base (synthesised from both empirical and experiential knowledge) which can inform practitioners (such as nurses or parents) in their daily practice
- (2) How to increase capacity in the system by creating a democratic exchange of published literature and experiential knowledge and skills across the professional/client interface.
- (3) How to optimise resource utilisation across the system to promote equity given finite availability of resources.

Procter (1995, p.71) proposed that there is a need to “realign the qualitative and quantitative methodologies” for practitioners to be participant researchers in knowledge production. This can be achieved by using both context specific reflective methods and quantitative methodologies in order to simultaneously add to the cumulative knowledge base by inductively analysing published empirical knowledge

in the context of practice situations. In this way, the established theory base (deductive framework) is used to provide a critical edge to interrogate and articulate the taken for granted and intuitive assumptions and beliefs, which have become too familiar to practitioners. Simultaneously the relevance of the theory base can be inductively analysed in the context of everyday practice. In this thesis, the cumulative set of nursing knowledge and skills derived from the nursing project (Croom 1996) was used as a critical edge to interrogate the taken for granted assumptions and beliefs of the parents in order to help them articulate their intuitive knowledge, skills and expertise.

Working with parents as co-researchers is resonant with the “collaborative group model” of Carr and Kemmis (1986) and Kemmis and McTaggart (1988), who promote the notion of a group of practitioners working together, as co-action researchers in order to question the relationship between the actual and the possible and to embark on a critical struggle for reform.

Background to Action Research and application to this thesis

It is widely acknowledged that there is no one single accepted definition or interpretation of action research (Rolfe et al 2001, Friedman 2001). In order to fulfil the specific remit of thesis, which is to carry out practitioner research in CAMH, whilst simultaneously offering a service, this thesis combines the perspectives of action science, a form of action research with critical theory. The background to these perspectives and the rationale for combining them will now be discussed.

It is generally agreed that the founder of action research was Kurt Lewin (Rolfe 1998). Lewin (1948, p.21) defined action research as:

“A way of generating knowledge about a social system, while at the same time attempting to change it”.

Lewin's original concept of action research has been described as a series of spiralling decisions, taken as the basis of repeated cycles of analysis, reconnaissance, problem reconceptualisation, planning, implementation of social action and evaluation regarding the effectiveness of action (McKernan 1991).

Lewin's work was developed in the USA and the philosophy underlying Lewin's action research was that a social process could be studied by introducing changes and then scientifically observing the effects of those changes on the process. Around the same time, in the 1950's, the Tavistock in the UK used action research as a problem centred approach, a commitment to establishing relationships with clients over time, a focus on client needs and an emphasis upon research as a social process (Hart and Bond 1995). Action research was adopted into education but went into a decline because of the emphasis on funding for hard scientific research and re-emerged with Lawrence Stenhouse in the 1970's in education (Rolfe 1998a). The re-emergence came about:

“in reaction to the increasing amount of research on teachers in 1960's and 1970's which had a tendency to turn professionals into objects of study in ways that did little for the teaching profession” (Hart and Bond 1995, p.32).

Stenhouse's philosophy was different from that of Kurt Lewin's in that Stenhouse attempted to marry the experimental approach of social science with social action by teachers in response to major social problems for the day (Stenhouse 1981)

Comparisons can be made between education research in the 1960's and the current situation in CAMH, where the funding streams prioritise the development of evidence derived from positivistic research while at the same time acknowledge that there is an urgent need to address the social consequences arising from CAMH problems and disorders. Furthermore, much work has been done "on" parents (as demonstrated in the Literature Chapter two) but very little has been done "with" parents, which has explored their 24 hour experiences of caring for a child with behavioural problems.

As discussed above, although action research has been incorporated into nursing research, there is a paucity of action research "with" nurses in CAMH and even less with parents. Action research in nursing emerged in the 1980's (Greenwood 1984, Lathlean and Farnish 1984). Sparrow and Robinson (1994) argue that the late development of action research in nursing compared to other practice disciplines such as education was due to nursing research having to establish its credibility in health care and initially this was attempted by emulating the medical positivistic research. This was followed by disillusionment with the potential for positivistic methods for developing practice. Action research approaches have thus been developed in nursing, firstly to bridge the gap between theory and practice and secondly in recognition that the aims and practices of nurses and hence the research methodologies are different from those for medicine (Rolfe 1998a and 1998b).

In this thesis the distinct focus is on collaborative research with parents as carers/clients in the recognition that a central aim of nursing is to develop knowledge and skills to provide 24 hour care and to support and empower their clients to develop the health capacity required to provide 24 hour care autonomously. Researching across this boundary between parents as carers or clients and nurses as providers is arguably central to nursing, as the reciprocal transfer of knowledge is integral to their role as emancipatory educators.

There are many different perspectives on action research some of which are contradictory:

“It should not be surprising that in view of the variety of different strands of action research, that a task of achieving a consensus on its definition is almost impossible” (Dole 1998 p. 174).

Elliot (1991 1985) argues that the primary aim of action research is to develop practice (Elliot 1991; Ebutt 1985) but the fundamental aim of action research is to improve practice rather than to produce knowledge. The production and utilisation of knowledge is subordinate to and conditioned by this fundamental aim (Elliott 1991).

Others argue that it is to develop knowledge and theory and that the development of theory is the final goal of action research. (Kemmis and McTaggart 1988). The researcher thus develops new or expands or enhances already existing scientific theory (Kemmis and McTaggart (1988). Others recognise that it needs to do both (Rolfe et al 2001). There is disagreement about the basic epistemological understanding of action research. McKernan (1991) reflects Lewin's (1948) understanding of action research and suggests that action research has to be strongly scientific. However, Cohen and Manion (1985) propose that action research

interprets the scientific method much more loosely and Winter (1987) proposes that action research rejects the scientific paradigm altogether as action science is not located within a natural science paradigm and is not concerned to provide “scientific” explanations of the world or to make a contribution to formal theory in foundation disciplines.

Titchen and Binnie (1994) described how they used an action research paradigm in working with nurses, where the aim of their research was the “improvement of practice and the generation and testing of a set of explanatory principles for nurses wishing to move towards patient-centred nursing to generate a theorised account or social theory about the journey from traditional nursing to patient-centred nursing” (Titchen and Binnie 1994, p.11).

They provided a discussion of action research:

"On one dimension, the intention of action research is to influence the real world. In this sense, it is like a controlled experiment, which seeks to deliberately control and manipulate reality, so that the effect of a particular intervention can be investigated. It is therefore unlike a case study or a survey, which attempts to describe and analyse the situation as it is. In the other dimension, action research, like a case study, may seek generalisation through social science as opposed to survey and experiment, which seek generalisation through probability theory and the use of statistics" (Titchen and Binnie 1994, p.11).

Action research is relevant to this thesis on the grounds that the fundamental aim of action research is to improve practice rather than to generate theory. Theory generation is seen as subordinate to and conditioned by the improvement of practice (Elliot 1991, pp 48-89). However, Titchen and Binnie (1994) discuss how “action hypotheses are continuously tested and reconstructed through the action research and that the action can be seen as “ideas in action”, which means that the action is theoretically informed” (Titchen and Binnie 1994, p.12).

In this thesis, the aim was to move from child-centred care by nurses in a residential unit to child-centred care with carers in the community in which cares were supported to provide the care for children with challenging behaviours in the community. This involved the generation and testing out of a range of propositions, derived from the previous nursing study as discussed in chapter 5. In this thesis, the intervention to be tested out is providing parents with the access to and critique of professional knowledge related to challenging behaviours (using the nursing framework (Croom 1996) and other published literature). Action research hypotheses are generated from this and are designed to ascertain how useful this knowledge is, how it can be refined and how it affects capacity. The hypotheses are tested out through the action research cycle and the key themes arising from this are synthesised into a theoretical framework, grounded in the context of the research. Applying the action research principles discussed by Titchen and Binnie (1994), enables future researchers to compare their context to the one discussed in the thesis in order to explore if the findings in this thesis can generate further insights and developments for the reader of this thesis and their practice context.

However, this thesis differs from the work of Titchen and Binnie (1994) in which the action research is carried out with fellow nurses/practitioners. In this thesis, the research is carried out with parents as co-researchers, who are also carers of the children with challenging behaviours and clients within the service provided by practitioners, including the author of the thesis, who is a practitioner researcher.

In this thesis, the scientific principles advocated by Lewin (1948) and McKernan (1991) of rigorously testing out the intervention in practice are adhered to, but the aim is to develop practice knowledge and theory and as discussed above, the emphasis is on external validity in the context of moment by moment practice. This is determined by the utility of the knowledge in the context of the everyday care situations experienced by the parents. It is recognised, therefore, that knowledge is not certain, but is contextualised and tentative and must therefore be developed in an iterative process and adapted to different contexts and situations.

There is also wide debate on the nature of collaboration in action research. Lewin (1948) and Holter and Schwartz-Barcott (1991) interpreted collaboration as being between “outside” academic researchers and “inside” practitioners. Reason (2003) proposed that collaboration was between the researchers and the subjects of the research. Carr and Kemmis (1986) saw collaboration as being between practitioners involved in researching their own practice with no help from professional researchers.

In this thesis, the practitioner researcher is researching her own practice and attempting to develop nursing practice knowledge whilst simultaneously collaborating with parents to develop their knowledge and skills and using this process to mutually inform the knowledge base of both. As there is clearly a serious

lack of consensus on what action research is and the aims and principles it could be argued that the thesis provides one more permutation of action research, which is essential when engaging in action research with clients, whilst simultaneously offering a clinical service.

However, for a practitioner who must simultaneously offer a service, there is a tension between acting as a neutral observer and taking neutral social science observations, when they hold an explicit role expectation to deliver effective practice. Practitioner researchers come into research with a set of values and take an ethical stance to offer an effective service. As originally conceived, action research such as that of Lewin involves a cyclical process of planning, acting, observing and reflecting in order to improve a situation or solve a particular problem. However, the elements of empowerment of participants and emancipation were missing in Lewin's conception of action research (Rolfe 1998a) The recognition of empowerment as a central feature of research with clients introduces a political dimension to the research and means that the values underpinning the research must be examined. However, this set of values must be problematised. The thesis attempts to achieve this through the use of participatory action research and critical theory.

Participative Action Research and Critical Theory

Although traditional action research does not inherently incorporate critical theory, action research studies are now frequently associated with Freire, Habermas and the Frankfurt school (Fontana 2004) and use a participatory design, such as the one used

in this thesis. Participatory action research (PAR) originates from the fields of adult education and the social sciences (Denton et al 1994, Smith et al 1993). It aims to be a more inclusive form of enquiry (Stringer and Genat 2004) and is often practiced in cross-cultural contexts (McTaggart 1991). PAR can be viewed as a way of “bringing participation into action research (Elden and Levin 1991). However, PAR is not seen as a method of conducting research but rather an orientation (Minkler and Wallerstein 2003) and it can involve quantitative, qualitative or combined data gathering methods, depending on the issue under investigation (Khanlou and Peter 2005). In working collaboratively with clients, this thesis uses findings from nursing research (discussed in chapter 5) that were derived from a diverse range of perspectives- both quantitative and experiential). This thesis thus uses action research but grounds itself in the participative action research tradition by using a range of methods and perspectives to achieve the goal of empowerment and emancipation. However, it is acknowledged in this thesis that one of the constraints to developing collaborative work and research partnerships between professionals such as nurses and parents is that nurses can also be argued to operate “professional closure” (Turner 1995) just like any other profession. Professional closure can set up tensions to collaborative working by tacitly defending the unique position of the professionals who are ascribed unique expertise. This must therefore be problematised as part of the research in this thesis. In order to achieve the thesis philosophy of practice change, emancipation and empowerment through critically analysing nursing and CAMH knowledge for their relevance to parents, the principles of critical theory within a participatory action research framework were applied within this thesis. In participatory research, Hall (1981, p.8) observed that “Although those with specialised knowledge/training often come from outside the situation, they are committed participants and learners in a process that

leads to militancy rather than detachment. Participatory research entails the mobilisation of people and enhanced awareness of their abilities and resources using social investigation, education and action in an interrelated manner (Hall 1981). In this thesis, the combination of the transfer of knowledge, the analysis of the critical incidents of the parents and the actions arising from the problem solving of issues raised by the parents were applied in the interrelated manner discussed by Hall (1981). In this way, the aim was to support the parents to take control of the problems they were having with their children, who had challenging behaviours and to develop the confidence to challenge their own responses and those of the extant systems and services that they were involved with.

Background to Critical Theory and its relevance to nursing practice research and this thesis

Research carried out in a socially critical scientific tradition is a response to the experience, needs and desires of oppressed people (Fay 1987). The parents in this thesis were marginalised from a socio-economic perspective as well as from a social perspective by having children who were perceived to have challenging behaviours. Fleming and Moloney (1996) argue that the term “oppressed” when applied to nursing research can be problematic because it can evoke images of tyranny or overt justice as opposed to the more subtle forms of hegemony which are common place in nursing.

It is generally agreed that Marx laid the foundations for modern critical theory (Crotty 1998, Fay, 1987, Harvey 1990). Marx proposed that the social order causes illusions that function to maintain oppression and he analysed the development of class struggle and class consciousness. The critical theory of Marx has been particularly

influenced and changed through the critical theorists of the Frankfurt school along with Habermas and Freire (Fontana 2004))

The Frankfurt school was founded in Germany in 1924 and provided an alternative to the prevailing positivists' paradigm and also a forum to debate and develop the critical theory of Marx. This resulted in a body of eclectic work, which did not become a consistent unitary theory, but the theoretical perspectives were all united by a critical approach to society (Crotty 1998). Habermas (1984) further developed critical theory, by using a systematic critique of the coercive nature of society and he defined emancipation as a process achieved through mutual understanding, critical reflection and communicative competence. Habermas (1984) identified that research with a critical focus was essential to expose hidden oppression and domination and to analyse and uncover hidden power structures, which could impact on the overall aim of achieving change, which is empowering for participants, particularly those from oppressed minorities. Habermas's work added emphasis to the expectation of social change in research involving critical theory (Fontana 2004)

Post modern and post structural theorists such as Foucault also examined the power (discourses) and can inform critical theory by their process of deconstruction and belief in multiple and contradictory realities (Cheek and Rudge 1994; Fontana 2004). Critical theorists agree that reality should be deconstructed to explore oppression, but then argue that society needs to be reconstructed in an emancipatory manner and thus criticise the post modernists for their inaction and failure to address persistent injustice arising from their belief that all theories are equal (Fontana 2004). Critical theory and critical nursing theory explicitly articulate that some perspectives are more

just than others and so incorporate a non relativist perspective informed by the value of social justice. Feminist theories are also emancipatory in intent and aim to uncover and transform oppressive realities and can be seen as a gender central, focused form of critical science (Morrow 1994, Blyler 1998). However, the purpose of this thesis is not to add to the theory of feminism or of critical theory per se, but to develop practice knowledge and theory in CAMH and to develop a process for professionals (such as nurses) to engage in participative research with their clients by applying the overarching emancipatory and ant-oppressive principles of critical theory. This thesis also explores whether emancipatory practice change in CAMH can be achieved through sharing and creating nursing knowledge on the 24 hour care of children with challenging behaviours with their parents, who are simultaneously receiving a service. In doing so, it focuses on the possibility of emancipation through the deconstruction of “professional knowledge” rather than gender, which underpins feminist theory.

Critical science in nursing is often connected philosophically and methodologically with the work of Freire (Fontana 2004) such as *Pedagogy of the Oppressed* (Freire 1999). Freire (1999) proposed that individuals need to emancipate themselves by overcoming the false consciousness caused by oppression. Freire's theory of emancipatory education discussed how liberation is a process of dialogue, problematisation and increasing critical consciousness or conscientisation. This emphasis on the development of individual autonomy and increasing empowerment and potential through increased insight and awareness has great resonance for nursing theorists such as Newman (1986) because a main function of critical nursing is to expose the oppressive features of society that hinder human health and potential. Furthermore, critical social theory maintains that theory and practice are interwoven

and that knowledge is a value laden creation (Calhoun 1995). Thus in nursing research, “critique is undertaken to promote social change and foster creative knowledge development” (Boutain 1999) This thesis explores how to use knowledge creatively to empower parents, but in doing so acknowledges the need for critical theory to problematise the potential power inequities and the hidden values and agendas within the nursing CAMH knowledge base derived from the previous research project with nurses (Croom 1996- discussed in depth in chapter 5). This nursing knowledge base was derived from a diverse range of sources including the traditional CAMH knowledge base, which as discussed in the literature chapter is heavily derived from a positivistic base and CAMH experiential nursing, neither of which have been critiqued within the CAMH field for their potential sources of oppression or emancipation to parents of children, who are perceived to have CAMH problems.

Application of critical theory to this thesis

Although there are numerous definitions of critical theory (Fontana 2004), the following section will discuss how critical theory is understood and applied to nursing and within this thesis. Fontana (2004) attempts to articulate a clear definition of critical theory to nursing by defining it as a critical synthesis of seven processes, which will now be discussed and applied to this thesis.

1. Critique

In critical theory, it is necessary to confront the ideology and structures of society through which power and domination are maintained and to expose the forces of injustice and oppression by examining power relationships and

imbalances within societal structures (Fontana 2004). This requires oppositional thinking, reflection and dialogue and asking such questions such as:

- Who benefits from this situation
- How is this situation maintained

However, it must be acknowledged that this creates a tension in practice situations. If society operates on hegemony, then those who are being oppressed are not aware of this. It is necessary therefore to find a way to help and support the oppressed to become aware of tacit oppression, to enable them to reflect on this and in so doing to consider ways to critique, oppose and change the oppression. In order to achieve this in this thesis, the parents participating in the research were supported through group work to develop a joint consciousness about their situation. They were supported and nurtured to identify their tacit assumptions and thus to question any tacit oppression. They were then encouraged to reflect on who benefits from the social structure as it is, how this is maintained and how it could be changed. In recognition of the potential power differentials between the nurse researcher and facilitators, the cohorts all engaged in a series of group sessions, designed to enable their sense of identity to build and their level of conscientisation of their own power and skills to be sufficiently strong to enable them to confidently critique both the nurses and the information that was shared with them.

In order to resolve a further ethical tension in which parents could potentially be made aware of oppression, but not have the capacity to change anything, an action plan was developed with the parents in the form of a practice framework

which could be shared across professional carer boundaries and so provide an ongoing way of continuing the emancipatory process. A critical discussion of the extent to which the framework achieves this will take place in discussion chapter 8 of the thesis.

2. Context

It is necessary to contextualise the phenomena of interest by addressing the historical, economic, political and social forces, which sustain it (Fontana 2004). Studies are situated in their historical and structural context and it can be argued that it is the context which sometimes causes the phenomena. Thus if the context is not changed, then it may continue to reproduce the same undesirable and oppressive situation. Critical theory must therefore address the historical, economic, political and social forces working to sustain the oppression.

In this thesis, the “phenomena” are the practice knowledge and skills related to the practice of 24 hour care of children in the community, who are perceived to have challenging behaviours. Historically, research in CAMH has been predominantly positivistic with the Randomised Controlled Trial given as the gold standard by powerful organisation such as FOCUS, an organisation of the Royal College of Psychiatrists dedicated to CAMH (Scott et al 2001). There is a wealth of published CAMH research using an experimental approach, but a dearth of nursing practitioner research in CAMH and research related to parenting tends to be positivistic rather than participative. This means that the tacit and experiential knowledge, which underpin everyday care have not been

articulated in CAMH. CAMH has a high priority on the government agenda as illustrated by the National Service Framework for children, young people and maternity services (DoH and DfES 2004) in which standard nine is specifically dedicated to CAMH. However, it could be argued that there are tensions in the current political environment, between maintaining the expertise and potential hegemony of medical and psychological sciences in CAMH through the use of the evidence-based research paradigm, currently extolled by dominant organisation such as the DoH and in addressing the apparent gap between efficacy in rigorously controlled clinical trials and effectiveness in the actual practice context (Hoagwood et al 2001).

Nevertheless, the government focus on CAMH means that there is a current political imperative to find new ways to meet high CAMH needs within a context of finite resources. Children with challenging behaviours have a high burden of illness arising from co-morbidity with crime and delinquency if not treated/managed therapeutically at an earlier stage (Knapp et al 1999; Offord et al 1998). The tensions arising from the apparently conflicting approaches of efficacy in clinical trials and effectiveness in actual practice are not articulated in the official policy documents such as the NSF (DoH and DfES 2004).

Critical theory is essential therefore to critique the current context and associated tensions and to help practitioners to work with the clients they serve to discover pragmatic, effective and emancipatory ways through these tensions.

3. Politics

Critical science assumes that knowledge generation is a political activity (Fontana 2004). Acknowledging that social forces shape the development of knowledge generation and its subsequent dissemination means that critical research does not pretend to be neutral, but is designed to expose unequal power relationships in societal structures and ideologies as well as those inherent in the research process. Knowledge and knowledge generation are not taken as a neutral, value free activity; instead critical social theory explicitly recognises that both knowledge and knowledge generation are affected by explicit and implicit values.

This position resonates with the practitioner research approach of this thesis described above, which assumes that the aim of research is to improve and develop practice, but also acknowledges that it is essential to articulate and critique the underpinning values of the research activity to do this successfully. In nursing, individualised care is a highly cherished value (Rolfe 1998a). Developing capacity in a context of high needs and finite resources is also essential in order to fulfil the value of equitable services. There is also a potential tension between providing equitable services for all and individualising care. Critical theory is essential therefore to critique such tensions.

Research questions informed by critical theory are designed to dig beneath surface appearances in order to expose underlying assumptions and are explicitly political in nature. In this thesis, the group process within each cohort involved helping the parents each week to identify any tacit

assumptions, which may be oppressive and to critique and challenge these.

The research cannot remain neutral and therefore the researcher must make their own agenda known.

4. **Emancipatory Intent**

The emancipatory intent of critical theory is a defining feature. Emancipation is defined as a “state of being in which people come to know who they are and have the collective power to determine the directions of their existence”

(Fontana 2004). However, “it is the possibility of change rather than the achievement of change” (Fontana 2004, p.94) which is essential in a study using this method. Habermas (1979, 1984) proposed that there is a need to develop and provide a critique of those elements of the social structure and culture, which deny individual freedom and growth by imposing unnecessary forms of social control and coercion on rational individuals. Gaventa and Cornwall (2001, p.71) describe how the incorporation of emancipation and empowerment requires participatory research, which challenges power structures and the tendency, discussed by Freire (1993), of relatively powerless groups to speak in a way, which echoes the voices of the powerful, either as a conscious way of appearing to comply with the more powerful parties wishes or as a result of the internalisation of dominant views and values.

Empowering individuals to acknowledge and question sources of oppression in their lives in order that they can challenge and change them are fundamental processes within critical theory. Within this thesis there are potential

tensions between the role of a nurse researcher, who is seeking emancipatory change and the ascribed role of nurses as agents of the state, who may tacitly seek to maintain the status quo. This thesis attempts to overcome this by setting up a context in which the parents can develop a joint consciousness and confidence to critique the nurses' perspective and a rigorous method of inductively analysing each proposition so that the parents have the opportunity to say when knowledge is useful or less useful and relevant in their everyday lives. The group processes were carefully monitored in order to help parents achieve this questioning position. Freire (1993) discussed praxis in terms of reflection and action upon the world in order to change and transform it. In this thesis the parents were supported to challenge the status quo and to consider what could be and not just what is, as discussed by Thomas (1993).

5. Democratic Structure

According to Fontana (2004) critical theory is characterised by a democratic, collaborative, non hierarchical relationship between researchers and participants.

The tensions involved in achieving democratisation of the research process within this thesis required critical analysis throughout the research, as it had to be acknowledged that I am not only a researcher, but also a professional with an ascribed role and accountabilities (discussed in more depth in chapter 5 and chapter 9). Hall (2001, p.172) discusses how "there can be no parity of interest between the researcher and their co-opted enquirers, but what can be achieved is a sufficient degree of inter-dependant collaborative reflection and

management of the research to be genuinely *with* people and not *about or on them*". The PhD study uses an iterative action science process to promote this collaborative reflection on action. Meerabeau (1995, p.41) discusses the new paradigm perspective and quotes (Reason and Rowan 1981), the feminist perspective (Oakley 1981) and action research perspectives (Carr and Kemmis 1986) as examples of research methodologies which actually pay attention to the research relationship and typically conceive the researcher/researched relationship as a co-operative partnership with mutual exchanges of information and insights and shared control over the progress of the research. When engaged in practice research, there is an additional tension, which arises from the practitioner researcher being socially ascribed more power than the parents. Applying the overarching principles of critical theory helps to interrogate this dynamic and whilst the tensions were acknowledged, this thesis did attempt to operate by democratic principles. The nursing knowledge was shared and disseminated with parents and the parents were actively engaged in critiquing this knowledge to discover how useful it was when applied to their everyday circumstances. Their analysis is reported in depth in chapter six. In addition, there was an explicit goal to learn from parents and to iteratively integrate their practice knowledge with the nursing knowledge from the previous study that this thesis builds upon, discussed in detail in chapter 5. As this nursing knowledge incorporated a diverse range of knowledge including published knowledge and professional experiential knowledge, the parents had the opportunity to contribute to the building of a cumulative body of knowledge and hence to become creators, not just users of services.

6. **Dialectic Analysis**

Critical theory understands that “Society is understood as a totality of contradictory elements” (Fontana 2004, p.94). Analysis consists of a constant shuttling back and forth between contradictions at a societal level and those at an individual level, between concrete and abstract and individual, objective and subjective. Studies, which incorporate critical theory, should examine the contradictory values, interests and conditions. In this thesis, a range of tensions and contradictions were acknowledged e.g. trying to create a dialectic position between taking an individual approach and incorporating research findings focused on generalisations and between being a researcher, practitioner and teacher and engaging in participative work with clients and between engaging in rigorous research whilst simultaneously offering a service. This is discussed further in relation to this thesis in chapter 9.

7. **Reflexivity**

Fontana (2004) argues that this process involves looking honestly at constraints and the forces which are potentially oppressive. Fontana (2004) recognised the importance of critical theory in helping the researcher to identify the multiple contradictions in reality and suggested that nurses should ask “why is the way we practice to-day different from the way we wish to practice?” (Fontana 2004, p.100). In this thesis this question is reformulated in order to explore with parents “*why are services the way they are and not the way carers want them to be*”? Fontana argues that change occurs through the resolution of the contradictions and the struggle. This thesis must analyse however, the opportunities and parameters to resolving these contradictions

when working with parents because parents are involved in a multitude of extant systems and the nurse will only have limited influence over some of these systems. However, the nurse can influence the distribution of knowledge and the opportunity to challenge tacit beliefs and assumptions with the parents, which may be acting to oppress them.

The seven principles of critical theory outlined by Fontana (2004) and discussed above formed the broad methodological framework for this thesis. As this thesis involved working in a participative action research framework to explore the potential impact on capacity through the transfer of knowledge, it was crucial to explore how knowledge can be used in an emancipatory sense rather than in reinforcing professional power and status. According to Habermas (1987) the production and development of true critical knowledge can only take place in situations of democratic dialogue and open communication e.g. the participants must be able to engage in unrestrained and unregulated debate, which is in principle unlimited, since it is only under these conditions that self reflective, critical and viable knowledge can emerge. Kemmis (2001) argues that critical theory provides a useful tool for analysing the relationship between professional groups and clients in terms of access to knowledge and the communication of information. Critical thinking can shift the focus from discrete instances of phenomena to their broader social context (Kemmis 2001). This thesis has attempted to explore how findings from participative action research with nurses in an institutional setting nursing can be transferred to a community context with parents, who have a range of vulnerabilities including socio-economic difficulties, social isolation, neighbourhood harassment and difficulties with schools and also how these parents can refine knowledge.

The principles of critical theory have been applied in a number of ways. Thomas (1993) identifies the central assumption of critical theory as recognising that “knowledge is a tool, in which new ways of thinking become implements by which we can *act upon* our world instead of *being acted upon*” (Thomas 1993, pp.20). Critical theory gives the researcher permission to adopt a moral or ethical stance and to use an “insider” perspective to highlight issues of power distribution, access to resources and to knowledge acquisition and production. Critical theory thus catalyses the researcher to analyse what “can be” and not just “what is” (Thomas 1993, p.20). It achieves this through challenging the underlying meanings and assumptions of research, policy and other forms of activity. Thus critical thinking can identify pre-existing cultural formations that shape behavioural opportunities and life chances and identify how participants can reaffirm, challenge or accommodate to existing formations. This thesis methodology aimed to articulate any tacit oppression experienced by the parents and to provide the means to support them to challenge this oppression through the emancipatory approach of participatory action research and critical theory.

Critical theory enables an analytic discourse which can identify “comfortable ways of seeing the world” (Thomas 1993:6). In this thesis, there was also an explicit aim to challenge the view of professionals as experts and identify processes in which the parent’s expertise can be revealed and may contribute to the evolution of a cumulative knowledge base.

Discussion on the validity of the research

The methodological process of this thesis is not intended to produce the statistical reliability and validity of experimental quantitative research. In the evaluation of traditional experimental research, validity involves the extent to which the research can represent reality and whether there is anything in the research which may distort reality. It therefore assumes that there is a reality independent of experience and that a “valid” study is one in which the causes of distortion or bias have been controlled in order that the findings can be successfully replicated in other contexts. In action science and participant action research, such as used in this thesis, the knowledge is derived from the experiences of the participants within a certain social and cultural context and so is constructed within a particular context and time. There is therefore a problem with generalisability and replication because it is not possible to control for the many intervening temporal, cultural and macro variables, which operate in the complex situations of everyday life. However, this does not rule out the need to apply rigorous scientific processes (Friedman 2001). Silverman (2000) proposes that “work becomes scientific by adopting methods of study *appropriate* to its subject matter” (Silverman 2000, pp.224). Action science research such as that used in this thesis is therefore “scientific to the extent that it uses appropriate methods and is rigorous, critical and objective in its handling of data”. As Kirk and Miller (1986:11) discuss, “The assumptions underlying the search for objectivity are simple. There is a world of empirical reality out there. The way we perceive and understand the world is largely up to us, but the world does not tolerate all understandings of it equally” (Kirk and Miller 1986, p.11). This means that it is necessary to “overcome the temptation to jump to easy conclusions just because there is some evidence that seems to lead in

an interesting direction” (Silverman 2000, pp.224). Silverman argues that it is essential to “subject this evidence to every possible test by making every effort to falsify our initial assumptions about the data” (Silverman 2000, pp.224). This is similar to Popper's (1959) method of critical rationalism, which proposes that “what characterises the empirical method is its manner of exposing to falsification in every conceivable way the system to be tested It's aim is not to save the lives of untenable systems, but on the contrary, to select the one which is by comparison the fittest by exposing them all to the fiercest struggle for survival” (Popper 1959, p.42). According to Popper (1959) our knowledge is only provisional and is subject to subsequent studies, which may come up with disconfirming evidence. Popper's scientific perspective can be criticised on the grounds that his argument is circular i.e. he proposed that it is possible to appeal to “facts” to test findings despite acknowledging that “facts can only be seen through particular theoretical lenses” Silverman (2000, p.237). However, from a practitioner research perspective and a participative action research perspective, Popper's work highlights the need to rigorously and iteratively search for disconfirming evidence and thereby provide a pragmatic way forward, which prevents practitioners and researchers from consciously or unconsciously maintaining the status quo and perpetuating their professional hegemony.

Silverman (2000) discusses how analytic induction can be used to generate and test hypotheses, which are grounded in qualitative data. This means identifying some phenomena (in this case that nurses have identified particular skills which appear to be useful in the 24 hour space) generating a hypothesis (that these skills will also be useful to parents) and then testing these out using data generated with parents. As

Fielding (1988, p. 7-8) describes “one case...is studied to see whether the hypothesis is related to it. If not, the hypothesis is reformulated (or the phenomenon redefined) to exclude the case, while a small number of cases support practice certainty, negative cases disprove the hypothesis, which is then reformulated. Examination of cases, redefinition of the hypothesis and redefinition of the phenomena is repeated until a universal relationship is shown” (Fielding 1988, p.7).

Silverman (2000, p.238) discusses how analytic induction uses two techniques:

- (a) The use of the constant comparative model (finding alternative cases to test out a provisional hypothesis)

[In this study the nursing knowledge and skills (Croom 1996) and the evolving practice framework were iteratively tested out with the parents throughout the 8 cohorts]
- (b) The search for deviant cases in which there is constant modification of the analytic scheme, which is continually confronted with negative or discrepant cases until the researcher derives a set of recursive rules, which incorporate all of the data in the analysis.

Through applying analytic induction in this thesis, the knowledge and skills from the nursing research (Croom 1996) were tested out systematically with the parents to explore if they were relevant and helpful or not so relevant to their everyday lives. Any new knowledge or data generated through discussion with the parents was subsequently compared to the published literature and then fed back to the parents for

further inductive analysis for the relevance of published literature to their everyday context. Maturana (1991) proposed that another perspective on validity is not replication but the ability of the research to be a generative mechanism whereby readers can gain an insight into the research experiences and discoveries in the particular conditions in which they were experienced. This means that the conditions under which the study took place must be articulated. By explicating the research experiences, this research study is attempting to rigorously develop generative validity.

Silverman (2000, p.34) suggests that in order to increase validity in qualitative research, there is a need to deal with not only the evidence/cases which confirm the particular perspective of the researcher, but also to deal with “contrary cases”. This enables an assessment of the representativeness of the evidence and can overcome the criticism that the researcher is only selecting those fragments of the data, which support his/her argument. As discussed by Silverman (2000) introducing simple counting techniques into the research can help to test and revise impressions and check out the accuracy of their impressions of the data. Such counting methods were used, where possible, in this research.

Critical analysis of reliability related to this research.

In traditional experimental research, reliability refers to whether the results are consistent and not subject to the vagaries of data collection. Reed and Biott (1995:191) propose that reliability checks in practitioner research might be more usefully thought of as exercises in sounding out interpretations. In this study, the

interpretation of the data was iteratively sounded out or checked out with colleagues at each stage. Furthermore the inductive analysis of the knowledge and skills in application to real practice problems iteratively challenged the interpretation and allowed the parameters of generalisations (Procter 1995, p.77) to emerge in the practice context.

Values Underpinning the Practitioner Research used in this Thesis

This Chapter has demonstrated that there are tensions in practitioner research of the type being undertaken in this thesis because professionals such as nurses are potentially ascribed a higher status than parents in therapeutic work and are therefore gate-keepers to further resources. Furthermore, as a nurse researcher I was accountable to deliver a service and not just engage in research. As a nurse researcher therefore, it was essential that I was transparent about my role and accountability as an agent of the state e.g. for child protection and how this would take precedence over the research.

The philosophy of the thesis is underpinned by practice research principles and the explicit belief that there is a need to improve practice in an emancipatory way i.e. in ways, which do not allow the interests of the experts to prejudice the interests of clients (Higgs et al 2004).

As a researcher, my agenda was to improve practice whilst offering a service in order to highlight the primacy of care and practice. I also wished to increase/explore ways

of increasing capacity and to challenge the boundaries of power from experts in services to client being co-creators.

The thesis aims to increase CAMH practitioner knowledge related to the collaborative work with parents, who are the main carers of children with challenging behaviours. It attempts to achieve this through the pursuit of collaboration with the parents as research partners, whilst simultaneously offering them a CAMH nursing service in the form of a parenting group, where strategies for the care and management of children with challenging behaviours are explored. The thesis involves both testing out the propositions (box 4 in chapter 5 p. 219) whilst simultaneously working in a collaborative and emancipatory way with parents by sharing the evidence base with them and discovering how parents can contribute to a cumulative body of knowledge and skills.

The major value underpinning this thesis is a belief that practitioners can and must contribute to the knowledge base if the knowledge base is to serve the interests of the clients we are accountable for. A further value is that practitioners must optimise all available knowledge and resources in a situation of high need and finite resources and therefore it is essential to build a cumulative knowledge base. A further belief is that practice knowledge is not definitive, but an iterative process. However, to avoid the perpetuation of a professional hegemony and to develop a clinical evidence base for practice using qualitative methods it is essential that carers (in this thesis) or service users, more generally, are valued not only as recipients, but as creators of services. This recognises that it is not only professional practitioners, who can make a contribution to the knowledge base, but also carers and other service users. For

nursing this is essential if we are to maximise the total amount of professional and lay caring resources in the extant systems of children with challenging behaviours. In order to be able to achieve this, "Practitioners need to be able to combine knowledge, reasoning and skills in practice" (Higgs et al 2004, p.81). There is therefore a need to discover to what extent academic published literature is relevant to practitioners and carers and how it can be refined and developed in order to discover the parameters of its usefulness. Higgs et al (2004, p.53) argue that "Practitioners need to use skills of reflection, theorisation and research to critique, refine and generate practice knowledge which can contribute to the public knowledge for use by their profession". This thesis is exploring the transferability of knowledge between nurses and parents.

In undertaking this research it is clear, therefore that the researcher was required to adopt an explicit political position in relation to the production of knowledge. The adoption of an explicit political position challenges the scientific validity of the research process and creates concerns that the findings were pre-determined by the political stance adopted. The processes of reflection and analytical induction which formed the key analytical processes used in this thesis were used specifically to address these concerns. In this context analytical induction was particularly helpful as it challenges the researcher to focus on the identification of evidence which disconfirms the emerging analysis and acts as a useful check against interpretations which merely reinforce the researchers preferred findings.

Summary of methodological rationale

As this thesis has demonstrated, there is no generic definition of action research, action science or critical theory and the many debates which arise from implementing each of these approaches remain unresolved in the literature. The thesis does not therefore, seek to resolve the multiple layers of complexity inherent in these methodologies, but to discuss a way of navigating through them for the purposes of this specific piece of research and to identify and analyse the emerging debates. However, the debates, which emerge can have a wider application and can be applicable not only to CAMH but also practice research, which seeks to improve practice whilst engaging in research.

In order to engage in research whilst simultaneously providing a service and to develop a cumulative body of knowledge, which is useful in an everyday context when managing children with behavioural problems, it was necessary to integrate an innovative combination of qualitative methods within a critical theory philosophy. Engaging in an inductive analysis of a deductive framework of a body of nursing knowledge and skills (Croom 1996) articulated by nurses in a 24 hour setting served to optimise the use of published literature and professional expertise without succumbing to the disadvantage of reductionism. The nursing knowledge and skills (Croom 1996) provided a practical technique to interrogate the taken for granted assumptions underpinning the tacit and intuitive knowledge of parents. The use of critical incident analysis helped to generate authentic data of the parents' everyday experiences. Action research was used to rigorously test out whether the application of the nursing knowledge was helpful to parents. Critical theory (Fontana 2004, McClaren 2001, Habermas 1987) was used to critique the methodological processes and the process of engaging in participative research, when there was a potential

imbalance of power between professionals and clients, to critically explore the relationship of the knowledge and skills to the social and political context of which the investigation is a part and to critically identify the potential for practice change, which is a fundamental outcome in emancipatory participative action research. Action research which is traditionally carried out as a partnership between academics and practitioners tends to work with practitioners to help them critique their current practice models and develop new and innovative approaches to service development (Rolfe 2003, McCormack et al 2003, Titchen and McGinley 2002). Similarly in action research undertaken with service users (Reed 2004) action research is used to give users a voice to identify the types of services they might prefer. In this type of research the new practice development arising from the action research becomes the focus for theorisation. In the research undertaken here, a new form of practice, derived from a diverse range of sources including quantitative research and qualitative research, was introduced and used as a basis for undertaking participative action research. The practice development utilised a critical perspective in order to facilitate service users to critique and develop existing services while simultaneously receiving care. The thesis illustrates and operationalises in a practice setting with clients how: "Participative action research is not a method of conducting research, but rather an orientation to research" (Minkler and Wallerstein 2003) and how this can thus "involve quantitative, qualitative or combined methods, depending on the issue under investigation" (Khanlou and Peter 2004).

Chapter 4

Description of Methodological Processes

This Chapter provides a description of the data collection process and the process by which the data was analysed in this research. It highlights the problems of capturing data while undertaking practitioner research with clients and describes the decisions taken to try and ensure a systematic approach to the collection and analysis of the data, whilst providing a clinical intervention. A key issue for this research was the need to distinguish between the practice development and research process. This Chapter describes the methods used to achieve this distinction and the difficulties and problems this gave rise to.

Context

The city in which the study was carried out is situated in the North of England and has a population of approximately 500,000. It has wards, which have been designated as being amongst the most affluent nationally as well as some in the east and west of the city (where the research was carried out) which are amongst the most deprived nationally.

The CAMH service operates as a teaching unit with links to both universities in the city and has district and regional out-patient services, day patient services and in patient services for 3-15 year old children. Nurses provide the 24 hour care in the residential unit and the 9.00 a.m. – 4.00 p.m. care of day patients and are thus in loco parents of these children. Nurses are supported by psychiatrists, psychologists,

occupational therapists, social workers and teachers, who provide sessional therapy and education. A multi-agency community service provides CAMH care for the city.

At the time the PhD study was carried out, parental groups to support parents of children experiencing mental health difficulties were not offered as part of the CAMH service despite increasing evidence of their effectiveness (see Literature Chapter for an account of the evidence base). This research arose out of discussions with local service managers about this gap in service provision and a critique of the current evidence base on parenting programmes. Permission was given to run a series of parenting groups across the City to trial this approach locally and to develop local expertise in the provision of this service. As discussed in the Literature Chapter there is a good evidence base for the effectiveness of parental groups, but there are persistent problems with uptake and drop out particularly by those with the greatest unmet need. Chapter 2 also highlighted the didactic nature of the group intervention processes reported in the literature format used in many of the groups from which the evidence of effectiveness is derived. A deliberate decision was taken at the outset to run the groups in this thesis, by using collaborative non-didactic methods and to analyse the impact of this approach on knowledge and skill generation of group members. The opportunity for parents to participate in a group constituted not only a research opportunity, but also an additional service for them.

Accessing a Sample

The sampling strategy for recruitment to the study was guided by purposive sampling (Miles and Huberman 1994). This is a sampling strategy in which people from a pre-specified group are purposely sought out and sampled. Purposive sampling is used to

identify patterns in the data of experience or response, but also to identify exceptions to patterns as these can develop the theoretical schema produced by the research.

As discussed in Chapter two, the literature (Cunningham 1995; Pugh and Smith 1996) has indicated that parents from lower socio-economic classes and deprived areas were the least likely to access parenting groups. It was therefore decided that the parents for this thesis would be selected from the most deprived wards in the City in order to explore how useful the nursing knowledge and skills were in the most challenging of conditions, how these conditions can impact on the capacity of parents to apply additional knowledge and skills derived from a range of sources and how increased insight derived from the findings of these explorations may increase the capacity of service providers to provide services, which are acceptable to parents and families. Recruitment of the parents took place therefore from four of the most deprived wards of the city.

Additionally, concepts underpinning theoretical sampling (Silverman 2000) were used to inform the sampling strategy in particular the sampling of the data for analysis. This is discussed in more detail below but the principles underpinning theoretical sampling will briefly be described here. In theoretical sampling the sampling strategy evolves iteratively in response to data analysis and in particular to the conceptual and theoretical aspects of the analysis rather than the characteristics of the population under study (Corbin and Strauss 1999). Undertaking this study with parents provided an opportunity to explore how transferable the knowledge and skills of nurses, (derived from nurses working in loco parentis in an institutional context where everything is provided) were to a community setting where there are additional socio-

economic, housing, educational and employment stressors as well as the inherent differences in emotional attachments with the children arising from being a parent. Purposive sampling combined with theoretical sampling therefore provided a method to explore what kind of knowledge is useful and relevant to parents in these socio-economically and emotionally challenging conditions. It also allowed a collaborative exploration with parents into how they experienced challenging socio-economic circumstances and how these impacted on their capacity to respond to children with behavioural problems.

Inclusion Criteria

Criteria for inclusion in the study were derived using the Pearce (1993) criteria for identifying significant CAMH problems, as discussed in the literature chapter.

Parents were recruited if:

- ◆ Their child was experiencing behaviour problems, which resulted in the child being unable to cope with everyday requests, limits and frustrations in a way, which was perceived to be socially and developmentally appropriate by the extant systems with which the child was in contact e.g. family, schools, recreational settings.
- ◆ The problems had been present for at least a month
- ◆ The problems were of sufficient intensity to be interfering with the child's, parent's and family's everyday functioning and ability to meet social, emotional or developmental goals
- ◆ The problems were causing significant distress to their families on a daily basis.

Preparation for the study

Janesick (2003) uses the metaphor of choreography to describe qualitative research design. She suggests “a good choreographer captures the complexity of the dance/story by using rigorous and tested procedures and in fact refuses to be limited to one approach to choreography The qualitative researcher is remarkably like a choreographer at various stages in the design process, in terms of situating and recontextualising the research project within the shared experience of the researcher and the participants in the study (Janesick 2003, pp. 46-47). In developing her metaphor, Janesick draws attention to the inevitability of the connection between the artistry of the researcher (dancer) and the unfolding of the research design (dance). This highlights the importance of paying attention to self within qualitative research. The topic of self in ethnographic research has been explored by Coffey (1999) who draws attention to the importance of locating the self, conceptualising the interpersonal field, recognising the embodiment of field work and writing the self into the study. Although both Janesick (2003) and Coffey (1999) focus on traditional ethnographic fieldwork, their insightful analysis of the delicate interplay between self and other in face to face research has relevance for this study. The following section describes the preparation for the study paying particular attention to the categorisation of self in fieldwork proposed by Coffey (1999).

Critical reflection on the impact of my own role in the research

A critical part of the preparation was to critically reflect on my own values, beliefs and experiences and how these impacted on the practice research process.

Working with parents in this PhD study meant a shift in my practitioner research role from being an insider researcher with CAMH nurses in the Croom 1996 study, which

this thesis builds upon and which is discussed in chapter 5, to a role with a more fuzzy set of boundaries with the parents where I was:

- ◆ An outsider to their experiences of having a child, who was experiencing CAMH issues
- ◆ An Insider from the point of view of being a parent of an eight year old boy
- ◆ A “hybrid” as a nurse with experience of 24 hour care for children with CAMH problems (within an institutional setting)
- ◆ An insider with parents in the joint therapeutic process, where we were jointly attempting to explore ways to provide strategies that are useful to 24 hour care of children with CAMH problems.
- ◆ An outsider as a professional with an ascribed role which incorporated accountabilities to the National Health Service and the university, which employed me.

As a clinician, I had to acknowledge that I would be accountable for offering a service to parents and I therefore had to find systematic and ethical ways of engaging in rigorous research. This meant that I needed to analyse in depth my role as a practitioner and to apply a methodology, which could problematise this role. During the course of the research, I was invited to the Department of Health in London to work on a national project for nurses. I gave at least one paper at an international conference each year. I was also awarded two international fellowships (one from the Florence Nightingale Trust and one from the Winston Churchill trust). Whilst these experiences arguably enhanced the quality of practice and the research analysis, particularly the fellowships, which were directly related to the research, I had to acknowledge the potential power related to my ascribed professional role as a

“specialist” in my field and how this could potentially mitigate against true collaborative work with parents. I thus had to carefully consider the range of methodologies, which could:

- Develop a dynamic tension between my professional/personal perspective and that of the parents in order to produce and analyse data in ways, which critically explore experiences from both an insider and outsider perspective in a sufficiently innovative/insightful way as to create new possibilities for practice.
- Shift the power base, which is characteristic of a professional/research relationship with clients or “subjects” to a collaborative partnership.

I had to acknowledge that I was bringing considerable academic and practice experience of working with parents of children with challenging and disruptive behavior problems and considerable experience of working with children with challenging behaviours to the research. This meant that I needed to both share this with parents, but also open my professional knowledge and practice to the critique of the parents and their experiences. Because of my experience, my professional accountability and my role of providing a service, based on my ascribed expertise, I acknowledged that I could not play the role of a neutral researcher in this research.

I was aware that I had access to the vast literature base in CAMH but I was also aware of the limitations of applying this quantitative literature to practice, because it was carried out in relation to expert interests rather than consumers. As a nurse practitioner researcher, I believed in the participative action research philosophy of doing research with people rather on people. A further nursing value that I

acknowledged was that children and families should be supported to develop their full potential.

I had developed some expertise in working with parents through being awarded an international fellowship to study parenting programmes in Canada with Professor Charles Cunningham, who has done extensive research in this area, as discussed in the literature chapter. The reason I chose to study with Professor Cunningham was that his work was evidence based, well written up in the research literature, aimed to involve parents in developing their own solutions and was comparable in content to other evidence based parenting programmes. Whilst I found Cunningham et al's (1995) programme extremely helpful in providing some key strategies that were useful with parents, I also felt that the programme relied on a manual, which was applied 'to' the parents and that they therefore had no active role in modifying the programme or contributing to future literature or a cumulative practice knowledge base. In my previous research, which is discussed in Chapter 5, I found how important it was for nurses to articulate the nursing practice knowledge and skills required for 24 hour care and that access to and analysis of a diverse range of knowledge in the clinical setting could be an empowering experience for nurses as carers providing 24 hour care. Recognising that knowledge is power (as discussed in Chapter 3) I wanted to provide parents with access to the nursing knowledge, derived from the previous study and to engage with them as active researchers. My core nursing value of working in an emancipatory way with clients, discussed in Chapter 3 and located in the literature of Freire (1998) and Gaventa and Cornwall (2001) led me to explore ways to support parents to critique this knowledge, as discussed in Chapter 3 and by having the chance to refine and develop it, to develop their sense of

empowerment by becoming active partners in developing a cumulative knowledge base.

As a practitioner researcher, I was ethically bound and professionally accountable to ensure that the parent participants in this thesis had their needs responded to, with the best evidence available. As a clinical response, the parents were thus given access to Cunningham et al's (1996) programme and in addition they were also given access to the nursing knowledge and skills, described in Chapter 5 as well as the opportunity to engage in the research process. The research is therefore influenced by my values to work with parents rather than on them and to provide them with a voice to critique the current knowledge base and to develop new knowledge that can be incorporated within a cumulative practice framework. As a practitioner researcher and as a clinician, the value of practitioner research is to produce change. This is located in the work of Schein (2001), discussed in Chapter 3. This chapter describes how I openly acknowledge the influence of my knowledge and values in the research process but also subjected them to critique and to a process of refinement. Chapter 9 is dedicated to a reflection on this process. The above process of reflection was shared with and then undertaken with the facilitators, who took part in this research and our common philosophy for undertaking the research was agreed.

Group Facilitators

There were two group facilitators for each group session in each cohort. In total there were four facilitators consisting of the author (A) and a school nurse (S) or health visitor (HV) or a leader of the local family centre (LFC). I worked as facilitator in all of the 8 cohorts with one of the above co-facilitators. The co-facilitators had all

volunteered to be involved in the research, were parents themselves, had completed a Diploma in Child and Adolescent Mental Health, which incorporated teaching on the evidence base on and practice of parenting programmes for parents of children with disruptive behaviour problems including Cunningham et al (1996), had an interest in developing community Child and Adolescent Mental Health services, were committed to working in partnership with parents and were also actively involved in the locality/wards chosen for the research. This meant that the co-facilitators could act as a source of continuity of support to the parents following the groups.

The fact that as group facilitators, we were also parents ourselves was an important consideration in setting up and running the groups and engaging in the research. It relates to Coffey's (1999) discussion of the embodied self. In in-depth qualitative research the researchers are in many ways the research instruments, their experiences and who they are colour the inter-personal relationships and in many imperceptible ways determine the course of events. As discussed in this Chapter and throughout the findings Chapters, as group facilitators we frequently drew on our own experiences of parenting in part to equalise the relationship with the participating parents. However, in doing so we had to ensure we didn't undermine the experiences of those attending the group or inhibit the articulation of the parents' experiences or analysis. It was important therefore to prepare well for the groups, to try and anticipate as many of these dilemmas and issues as we could and to identify our ethical and clinical response to them.

Preparation for research and practitioner intervention

Prior to the research, we engaged in extensive preparation. This preparation involved:

- (1) Agreeing the format for the home visit and the consent form to ensure that the parents all received information about the aims and structure of the research and reassurance that their future access to CAMH service would not be compromised.
- (2) Developing a joint understanding of the nursing propositions (derived from the previous study and discussed in depth in chapter 5, pages 219 and 233) that were to be tested out in the course of the research and the experience and literature underpinning these propositions.
- (3) Developing a joint understanding of the research methods including inductive analysis i.e. that we were exploring whether the knowledge and skills underpinning the propositions were useful to the parents in their context or not.
- (4) Developing a joint philosophy of practice research, that incorporated the principles of critical theory and emancipatory action research in which we would explore with the parents 'what can be' and not just 'what is'. This meant critically looking at our approaches to actively recognise any hidden agendas or tacitly oppressive assumptions. We decided to use the skill and support of the external supervisor to support us in recognising these assumptions.
- (5) Agreeing how we would use the parent's own experiences to apply the principles of critical incident analysis as a tool to engage in reflective action cycles with the parents (illustrated in figure 1, page 188 and opp. page 188).
- (6) We agreed that we would collect field notes/reflexive notes in each group session and share these with each other and also with our external practice supervisor (SW).

- (7) We agreed a protocol for operationalising the research alongside the practice intervention in this study (Appendix 11).

Preparation for groups

Preparation for the group work was an essential phase of the research (Krueger and Casey 2000). In preparing for the first cohort, the group facilitator and researcher had to locate themselves within the dual aims of their clinical/researcher role, which required that as clinicians we provided parents with a clinical service, whilst carrying out collaborative action research to improve practice. This meant planning how to run the groups in a way, which was not didactic and led by the research team as experts, but which offered the parents the opportunity to access and critique a diverse range of knowledge and achieve their aims of meeting the needs of their children. We therefore had to conceptualise the inter-personal field (Coffey 1999) in preparation for the data collection and maintain a constant critical check on the evolution of the inter-personal field as the research progressed. As Coffey (1999) points out fieldwork relationships do not just happen. They are the outcome of negotiation between the researcher and the participants. Throughout the research process the researcher is actively engaged in creating working and personal relationships. Often these relationships are bound by ethnographic tensions or in the case of this research, clinical tensions – for example between familiarity and distance, engagement and strangeness. These ethnographic tensions are also found in clinical relationships. For instance Benner and Wrubel (1989) recognise that caring is fundamentally about values and they highlight the role of personal concern as core to caring, describing in great detail the difficulties nurses can experience in de-personalising their caring activities. These similarities between familiarity and distance, engagement and strangeness in ethnographic and professional work provided a framework for our

conceptualisation of the inter-personal field. In this we recognised that we had to ensure that:

- ◆ We were responding to the needs of the parents across each cohort by promoting the opportunity for parents to develop their own solutions, by sharing the content of a traditional parenting programmes (Cunningham et al 1996) as well as the nursing knowledge and skills from the nursing study (Croom 1996, Croom et al 2000) and any additional learning arising from previous cohorts, and by iteratively comparing emerging themes to the evidence base to explore if further insights could be identified and then checking these with the parents for their usefulness in their context.
- ◆ We were working collaboratively rather than didactically with the parents with a therapeutic and respectful relationship
- ◆ We were picking up how the nursing knowledge and skills were being refined and registering any new knowledge emerging from the parents
- ◆ We were sharing our own experience as parents and professionals in ways, which were helpful to the parents in the group i.e. we had to monitor that we were not imposing our views or projecting any unresolved problems of our own into the group.
- ◆ We were acknowledging all of the positive aspects and skills of parenting that the parents were demonstrating, modelling how to genuinely give positive feed back to the parents and encouraging the parents to take the lead in the group.

External Supervisor (SW) for peer audit of research and group processes

Engaging in multiple roles in research, can be difficult to manage and can result in loss of perspective because the researcher can become over committed to anticipate

outcomes (Seymour and Davies 2002). In acknowledgement of this, a senior social worker (SW) in CAMH with extensive experience of group work, supervision and research was recruited to supervise the group processes in order to develop insight into the group dynamics from another professional perspective, to “audit” that the parents were receiving a good clinical service whilst engaging in the research process. In addition to the academic supervisor, the external supervisor provided peer audit of the data analysis and the patterns and themes emerging related to the usefulness or not of the propositions, the knowledge the parents were bringing to the sessions and the emancipatory knowledge that developed from engaging in a critical analysis of the tacit assumptions and beliefs that were potentially oppressive to carers of children with challenging behaviours.

Recruitment of the Participants

Purposeful and theoretical sampling guided the decision to focus on parents of children experiencing mental health problems living in some of the most deprived areas of the City meant that inevitably we were trying to recruit from the most hard to reach populations. Faugier and Sargeant (1997) discuss the difficulties of recruiting hard to reach populations. They advocate a variety of forms of snowball sampling. In snowball sampling, the respondent is asked to mention other persons, according to some inclusion criterion defined by the researchers. Here samples are created by a series of referrals that are made within a circle of people who know one another.

In this study all parents were recruited from a targeted population i.e. they met the inclusion criteria for referral to CAMH services as set out by Pearce (1993) described above. The parents of children on the CAMH district service waiting list were

approached to take part in the study, additionally parents were referred to the waiting list and the research by community health colleagues such as nurses, community paediatricians, educational services, GP's and social workers. Snowball sampling normally implies accessing samples by getting members of the community under study to refer others in that community to the researcher. In this study snowball sampling was used by asking professionals to refer clients whom they thought might benefit from the intervention. This approach to snowball sampling raises additional ethical issues. Like Randomised Controlled Trials, it raises potential concerns about coercion and informed consent particularly where clinical treatment and research are combined (Wilson and Rose 1998), as was the case here. Potential recruits were assured that declining to take part in the research would not prejudice their access to other statutory services and that the parenting group was an additional service which they were invited to attend.

A home visit was carried out by one of the group facilitators to each family, who agreed to participate. This was important as the group facilitators worked with the local community and were often known to the potential recruit. Developing a trustworthy relationship (Lipton 1994) is often seen as crucial in qualitative research. However, the evolution of trustworthiness within the relationship depends on understanding and problematising the interpersonal tensions in research described by Coffey (1999). In this case the professional integrity of the facilitator and their reputation among the local community was an important factor in determining uptake. In negotiating access to a sample it was important to take account of the local community context including the potential recruits' relationship with services locally. It was also important to ensure that the research did not disrupt or challenge pre-

existing inter-personal relationships including relationships with local service providers on whom the participant may depend such as teachers and GPs.

The aim of the home visit was to ensure the children met the research inclusion criteria, as given above, to support the parents to attend the group, to gather information on the family issues and background and to provide information to the parents on the groups, their timing and location. Although an information sheet was left with each parent (see Appendix 4), each facilitator also explained the study verbally and checked out the parents' understanding of the research and its background, in order to ensure that parents with literacy skills were not disadvantaged. The aims of the groups were explained to the parents as being:

- To provide support for parents and for parents to support each other
- ◆ To meet other parents to explore their experiences in caring for children with behavioural problems in their everyday context and to share good practice.
- ◆ To engage the parents as co-researchers in order to explore how useful knowledge and strategies derived from nurses were to parents, identify any further information which may be helpful and also to learn new knowledge and skills from parents.

The parents were reassured that participation in the parental groups would in no way affect their right to services. If parents agreed to participate, their written consent was obtained at the home visit.

Ethical consideration

As the thesis incorporates critical theory (Fontana 2004), which aims to purposefully surface constraints, contradictions and hidden agendas, a code of ethics had to be an

integral part of the research. This meant that the ethical issues had to be shared with the parents. At each stage of the research and throughout the research, the participants were warned that the research was to improve services and to develop change and that it could involve exploring issues that may be uncomfortable. They were also given assurances that they would be supported to deal with any uncomfortable issues, which arose in the group. Furthermore, in order to provide continuity of support following the groups, the co-facilitator in each cohort was a permanent health /social care professional based in the parents locality and had agreed to offer ongoing support, following the research.

It was crucial that the parents invited to participate were not disadvantaged by agreeing to participate in the research or declining to participate in the research. All of the parents involved in the research were either taken from or were candidates for a waiting list, which was at least 6 months long. Their informed consent was sought. By agreeing to participate, they were provided with the opportunity to rapidly access a service through the parenting groups. Neither their position on the waiting list nor their right to subsequent individual assessment and therapy were affected by their participation in the research groups.

However, it was acknowledged that the process of obtaining written consent can be a tool to satisfy organisational demands and to protect the researcher rather than the participants (Fleming 1994). The nature and direction of the research was thus discussed at the beginning of each group session, so that an ongoing process of consent was actively and iteratively negotiated. Parents gave their permission for the groups to be taped, but were encouraged to turn off the tape if at any time, they did

not feel comfortable with being recorded, although in the course of the research, none of the parents chose to do this.

In order to fulfil the aim of engaging the parents in participative research, it was crucial to share the data and analysis with the parents. As these parents were already overloaded and vulnerable, they identified that they did not want to be burdened with transcripts and so it was agreed with them that summaries of themes from the previous week would be shared with them and checked out and critiqued by them at the beginning of each group session across each of the 8 cohorts. Appendix 11 gives a description of the overall protocol for carrying out the group sessions.

Ethical approval was sought and successfully granted from the local ethics committee with due consideration given to safety, anonymity, confidentiality and expected involvement of participants.

Description of groups/cohorts

A total of eight cohorts of parents were engaged over a series of eight consecutive groups from January 1998 to December 2001. Each cohort of parents was given access to both the practice interventions (access to a therapeutic group to explore their experiences in caring for children with disruptive behaviour problems, access to the nursing knowledge and skills, access to the evidence base on parenting programmes and any further literature pertinent to any themes which emerged in an analysis of their experiences) and they were also engaged as participants in the research (see Appendix 11 and Figure 1, page 188). Four cohorts were held in community health settings in the most deprived area in the west of the city and four in the most deprived area of the east of the city. Each group had 12 - 14 sessions with an average of 12.6

sessions. The number of sessions varied according to the number of sessions required to respond to their clinical needs through the research process/clinical intervention in which the parents engaged in reflective learning cycles, where they inductively analysed the propositions discussed in chapter 5 (boxes 4 and 5 pages 219 and 233) and had access to a wide literature base including access to a traditional parenting programme (Cunningham et al 1996).

The minimum number attending a group session was one and the maximum was five.

Seventy-five parents met the inclusion criteria. Fifty parents agreed to attend out of the total of 75, who were invited. Forty five parents attended the first session and then a further 20 dropped out and so 25 parents out of the 75 became active research participants and attended at least 75% of the sessions, including the first and last session. A socio-economic profile of the parents is given in Table 1 below.

<u>Table 1</u> Social Characteristics of Parents invited and those who became active research participants	Parents invited to participate	Parents, from 75 invited who agreed to attend	Parents, from 50, who agreed to attend, who only attended first session of group, but did not attend subsequent sessions	Parents who became active research participants and attended 75% of sessions (n=25)
Gender	75 Female	50 all Female	20	25 Female
Owner occupied house	1	1	0	1
Council/Rented accommodation	74	49	20	24
Educational qualifications beyond 16	1	1	0	1
NVQ	1	1	0	1
Single Parents	74	44	20	24
Married	1	1	0	1
Living on Social Assistance	74	49	20	24
Employed	1	1	0	1

As can be seen, the socio-economic factors are comparable for the 75 parents invited and the 25 parents who attended 75% of the sessions and who actively participated in the research. Only one parent from the 75 invited was in employment (social class IV), had an owner occupied dwelling and education beyond 16, which consisted of an NVQ. This parent subsequently became an active participant in the research.

Running the Groups

Cunningham et al (1998) discuss the importance of working collaboratively with parents to develop their insight and motivation to change. In order to facilitate this, he advocates a set of cognitive attributional questions (see box 2, page 59)

Cunningham et al's (1996) attributional questions were incorporated in this thesis to gain parents motivation and participation and to maximise the capacity of the parents to engage in the research process through an active reflection on their own experiences. The Cunningham et al (1998) programme outline is discussed in Chapter 2 (Box 3, page 60) and was incorporated into the practice research protocol (Appendix 11).

All of the groups/cohorts in this thesis were held in local community health clinics or family centres, which were easily accessible for the parents. In order to create a supportive and cohesive group atmosphere, the chairs were arranged in a circle in a room, where privacy and confidentiality could be maintained. The facilitator, who had done the home visit, welcomed the parent(s) into the group. Refreshments were available at the beginning of each group and this provided a regular, structured "break" in which the parents could gather their thoughts (they were often rushing

from shopping or seeing children into school) and helped to develop group rapport and trust.

A description of the group processes is given in the protocol Appendix 11. In the group introduction on the first day of each group, the facilitator used the principles described by Cunningham et al (1996) to acknowledge how anxiety provoking attending groups can be and an ice-breaker exercise was used in order to try and create a relaxed atmosphere and to address anxieties. We used an exercise called "Fears in a Hat" (Cunningham- personal communication) in which everybody worked in pairs to identify the fears they had experienced that morning about attending the group and were asked to write them down on a piece of paper and put them in a hat (as facilitators, we had to be alert in case any of the members had difficulties with literacy and to sensitively help out). As facilitators, we shared our own anxieties e.g. that people might not turn up, that we may not come across well etc. Each member picked a "fear" from the hat and either read this out loud or gave it to the facilitator to read. This exercise often engendered a great deal of humour but also helped to bring into the open any anxieties, which may have interfered with the parent being able to engage in the group.

Following this, there was an open discussion about the groups and the research component. The facilitators acknowledged that as professionals, we were acutely aware that we did not have all of the answers, but would share what knowledge and skills we had with the parents. We emphasised our aim of learning from the parents and also of genuinely discovering from parents which knowledge and skills they found helpful in their everyday context.

To help us implement our emancipatory philosophy, we used the work of Reimers and Teachers (1995) by openly adopting a 'not knowing' stance. To facilitate the rigorous implementation of inductive analysis of the nursing skills and the and action research process, we acknowledged with the parents that it was useful to discover when they found the nursing skills useful but that it was equally useful to discover when they did not find them useful. We also acknowledged that the group was a learning experience for us all and that we hoped to build on the outcomes of the group to develop knowledge that could be shared with future parents, but also to inform other professionals.

To aid transparency of our professional roles, we also acknowledged our professional accountability. We were honest and transparent about our child protection responsibilities and attempted to reassure parents that if any situation arose in the group, indicating that a child had been hurt or could be hurt, that we would discuss this further with the individual parent. We agreed with the parents that if any subsequent referral to social services was necessary, this would first be discussed with the parent and explained that although safety was paramount, that an aim of the referral would be to mobilise as much support as possible for parents, who were clearly demonstrating their commitment to meeting the needs of their children by attending the group.

The parents were given both verbal and written reassurance that their access to services would in no way be compromised if they did not wish to engage in the research (Appendix Five). Their verbal and written permission was sought and

obtained to tape record the sessions and they were informed that they could switch the tape off at any time.

Each group was invited to generate ground rules, which aimed to maintain the dignity and respect of everyone in the group and group rules e.g. whether there should be a break and at what time (Krueger and Casey 2000, Cunningham et al 1996) and the aims for the group were then jointly negotiated. The parents agreed to explore the knowledge and skills from the nursing research (and as the groups progressed, any learning arising iteratively from the groups). We agreed to share with parents any other knowledge, which appeared to be relevant to the issues being discussed, so that the parents could analyse whether they found the additional knowledge useful or not. Comparison of the nursing research, upon which this thesis builds with the evidence base on parenting programmes, such as Cunningham et al 1995, demonstrated that the nurses' knowledge and skills (Croom 1996, Croom et al 2000 and discussed in chapter 5 that were derived from a diverse range of literature, incorporated the strategies employed in a traditional evidence based parenting group, but in addition used the literature on information processing and attachment and experiential knowledge such as the importance of peer group interactions. In this way, the parents were offered a parenting group, which incorporated the evidence base but they had the additional advantage of critiquing it, having access to the findings from nursing research with children with disruptive behaviour problems and also of learning from each other.

Data collection methods

Data collection was a particularly challenging aspect of this study. Demographic data was collected at the home visit or at a time convenient to the parent. The integration of research with practice meant that one of the difficulties was how to demarcate the data from the on-going clinical process. It also meant that the on-going clinical process had to incorporate and adapt traditional data collection methods. Qualitative studies such as grounded theory use qualitative data that has arisen from participants who are involved in the study. However, the nature of research in critical social science is one of collaboration and research processes are jointly owned by the researcher and participants, all of whom become co-researchers. This is indicative of reciprocity (Fleming and Moloney 1996). The concept of reciprocity implies notions of trust and mutuality, which provide firm foundations upon which rich data may be derived (Fleming and Moloney 1996). Fleming and Moloney (1996) have identified five components which develop reciprocity in research:

(1) *A shared commitment to the necessity of the research;*

In this thesis, this was achieved through both the nurse researcher and the parents negotiating a shared commitment to work together to find ways of caring for children with challenging behaviours in a 24 hour context.

(2) *The research agenda focuses on topics of mutual concern;*

In this thesis, the parents and facilitators agreed that developing knowledge and skills and developing and improving the capacity to respond to children were of mutual concern.

(3) *Control over the research process is equally shared;*

This was operationalised throughout the research by seeking the parents' views and through feeding the analysis of the transcriptions of the previous week back to them at the start of each group session.

(4) *Outcomes of the research are of equal value to the participants;*

In this thesis, both facilitators and parents agreed that discovering knowledge and skills to cope with children with challenging behaviours in a 24 hour context are of equal importance to both nurses and to parents in improving care.

(5) *There is fairness and justice among participants*

The facilitators acknowledged the potential power inequity between professionals and parents and applied critical science techniques to problematise this and encourage the articulation and recognition of any hidden power relationships.

All of these areas were discussed with the parents in this thesis at the home visit and were also constantly renegotiated throughout the group sessions for each cohort.

In critical social science, participants begin with a general feeling of dissatisfaction and accept that change is needed. The decision to target parents, whom research has identified have difficulties in engaging with services (Cunningham et al 1995, 1996), for recruitment to this study was based on an assumption that their failure to engage may arise from a dissatisfaction with current services and that the opportunity to contribute to research that is designed to change services may therefore appeal to them. Critical social science also includes an assumption that the researcher has in-depth knowledge of the subject before entering the field and are therefore extended an invitation to participate' (Fleming and Moloney 1996) as they are seen to have something to contribute. The researcher and co-facilitators in this thesis had all had

experience of working in a residential (24 hours setting) with children with challenging behaviours and also with parents in the community and indeed were all parents' themselves. The importance placed on the researcher contribution to participants in critical social theory contrasts with the interpretative paradigm where grounded theorists avoid contamination of the field by the imposition of prior knowledge. For instance, Husserlian phenomenologists bracket pre-existing knowledge and traditional ethnographers seek data from one or more key informants (Fleming and Moloney 1996).

The nature of critical social science tends to ask 'why' questions of the participants. In this research, the participants were asked why knowledge was useful or not so useful in their everyday lives. Socially critical data are characterised by a cyclical process in which the problem is visited at different levels (Fleming 1996). The end point of data collection in many interpretative methodologies is when no new material emerges and saturation is reached (Charmaz 2000, p.520). Due to its cyclical nature and therefore cumulative nature, emancipatory research has no clear end point. Fleming and Moloney (1996) described how the end points for their projects were made on the basis of time and this was also the case for this thesis. 'Taken to the extreme, if one is true to the philosophy of critical social science, research could never be complete' (Fleming and Moloney 1996, p.121).

In working with parents, rather than fellow professionals as research participants rather than fellow professionals, it was essential to find pragmatic and acceptable methods to facilitate parental participation. Critical Incident analysis was found to be

a useful method to both achieve the parents' participation and to integrate the research and clinical aspects of the study.

Critical Incident Technique

Critical Incident Technique was first described by Flanagan (1954). He used it to identify errors and near misses in pilots learning to fly planes and advocated it as a method for identifying learning opportunities embedded in every day experience. According to Flanagan (1954) a critical incident is defined as 'Any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the act' (Flanagan 1954, p.327). It must occur in a situation: where the purpose or the intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effect (Flanagan 1954, p.327).

In nursing critical incidents have been incorporated into a wide range of data gathering methods including being used in semi-structured interviews with the purpose of gathering information about specific critical incidents related to the behavior under investigation (Polit and Hungler 1995). A critical incident is defined as a decisive situation if it makes a significant contribution, either positive or negative, to the general aim of the activity under investigation and is of great importance to the person involved (Flanagan 1954). The primary objective is to collect descriptions about factual incidents that can enlighten our understanding of why and under what circumstances people act the way they do.

According to Atwal (2002) the critical incident approach is unique in that it does not measure satisfaction or dissatisfaction, but discloses individuals' likes or dislikes, and

allows subjects to talk about the events they consider important. It is therefore an extremely useful guide to illustrate what changes may need to be made. Critical incidents can be collected from either direct observation or retrospective accounts. It is a flexible technique that has been adapted to evaluate patient perceptions of nursing care (Grant & Hryack 1985, Norman et al 1992) and to evaluate performance (Cormack 1983, Benner 1984). The link to change and improvement, particularly in the context of learning which gave rise to the technique is relevant to this research, which explored the potential for change and improvement that may be achieved if current knowledge and literature is disseminated to parents in an accessible format. However, understanding the parenting context and the constraints this imposes on knowledge use was also seen to be important.

In this study the principles of critical incident technique were used as both a clinical therapeutic tool and as a focus for data collection. This meant the method had to be adapted to meet both sets of imperatives. During the course of the parenting group each parent was asked to engage in reflection on actual experiences, which were meaningful to them because they had managed them particularly well or alternatively, not so well. The parents were asked to describe the incident, its context, what they did, what they feel they might or could have done and what they have learned for the future. This reflects the approach described by Flanagan (1954, p.327) who recognised that critical incidents can be used as a method for ‘...collecting [direct] observations of human behaviour in such a way as to facilitate their potential involving practical problems.’ In this case, retrospective accounts were used rather than direct observation as described by Smith and Russell (1991). The tensions

involved in using the incidents for both data collection and therapeutic input are described below.

By using parent's actual reports of critical incidents, it was possible to support parents to reflect on authentic experiences and develop a group consciousness regarding these experiences prior to them giving access to the nursing knowledge and skills. This helped to address the potential power differential between the facilitators and parents, in which there was a danger of simply imposing the nursing framework and our professional agenda onto the parents. Critical incidents were also used as a way of capturing data related to the parents' tacit taken for granted intuitive knowledge and skills, which they would find difficult to articulate and disseminate to professionals. This was an explicitly participative process in which parents were invited to discuss particular incidents, that had occurred in the past week and which stood out for them because they felt they had gone particularly well or not so well. However, the nature and uncertainty of practice meant that it was not always possible to record and analyse the incidents with the parents in the ordered and systematic way in which it had been found possible with fellow professionals.

In the reality of the clinical situation it was not unusual for an incident to be discussed over the course of several weeks, with parents referring back to it and re-analysing it in the light of new insights, as described above. At other times, the parents were in a crisis situation e.g. experiencing severe housing difficulties, which had to be discussed before the group could focus on the group/research business. Initially the parents needed encouragement to focus on any one particular experience, because their previous week had usually been full of stress and incidents making it difficult for

the parents to disaggregate one particular incident and often the 'incident' was crystallised or integrated with group discussions in an anecdotal way which resembled story telling. The critical incidents thus became a tool to engage in reflective action cycles i.e. a discernable cycle in which the parents identified the problem, reflected on it, developed their understanding, first through group discussion and then through group discussion and access to the nursing knowledge and skills, developed action plans, tested them out in their own context, evaluated them and thus generated further refinements. As new incidents were generated, the learning from previous action cycles was incorporated, so that there was an iterative cycle of inductively testing out the nursing propositions by using the parents' experiences.

Focusing on completed reflective action cycles thus helped us to collect research data without disrupting the caring process and the development of a trusting relationship with the parents. This thus addressed the problem of prioritising the clinical and therapeutic aspects of the group over the need to collect data systematically.

From a clinical/therapeutic perspective the aim of the initial part of each group session was to provide the group members with some time to catch up with each other and discuss how their week had gone. The parents reported that they found this an essential component of the group in which they could ventilate difficult feelings and unwind. At first, the group facilitators became anxious that these sessions were becoming rambling or moaning sessions that did not follow the traditional format of critical incident analysis or indeed therapeutic processes. However, we quickly discovered that during these discussions, a range of incidents, that represented very rich data, were informally brought up. The facilitators then asked permission from the group to explore a particular situation that had been introduced during the preliminary catch up discussion and to analyse what we could learn from it. In this way the

researchers were facilitating the learning in the group but also teasing out the incidents which they felt might create learning opportunities as well as opportunities to develop the analysis. Throughout the data collection there was always a fine balance between providing a service and engaging in research with parents and so sometimes it was necessary to provide support to the parents, to allow the time for them to receive support from each other, before we could progress onto the research or clinical work.

When a clear experience emerged, we then began as a group the reflective action cycle. We identified as a group all of the positive aspects of the parents' behaviour and the solutions manifest in the incident. Initially the facilitators had to model this, because the parents tended to see their behaviour very negatively, but through encouragement, the parents began to take the lead on providing positive feed back to each other. The group then generated a range of potential solutions to any problematic issues that had arisen in the incident described. Parents were thus invited to share their own experiential knowledge of strategies, which they had found helpful in their own context with the other parents. We then engaged in a critical discussion to identify the potential advantages and disadvantages of the different solutions generated. Following the critical incident analysis, relevant aspects from the nursing knowledge framework (Croom 1996) and the propositions arising from this were shared with the parents, who then discussed whether the nursing knowledge (and as the cycles progressed, additional learning from previous cycles) was helpful (or not) in producing any additional insights or solutions.

The parents were then asked to discuss how the total set of solutions and insights that had been identified could be applied/generalised to their own context at home. They were then asked to try out these solutions in the following week, so that we could discuss, in the following group sessions, how helpful (or not) the parents had found them in real life situations. Solutions were written up onto flip charts, so that the facilitators could get them typed up and give a copy to each parent at the following group, ready for discussion. (Please see Appendix 6 to illustrate this process in which information was given on temperament, the solutions was generated to caring for a child with a “challenging temperament” and the responses were recorded and checked back with the group the following week).

In order to meet the parents’ clinical and therapeutic needs as well as research needs, the principles of critical incident technique were thus applied in a flexible way.

Consequently, the discussion and elaboration of incidents through the reflective action cycle could span several weeks or be iteratively discussed as the parents gained further insights. In the findings chapters all the data relating to a specific incident have been brought together to form a coherent account. However, in the reality of the research setting the incident was often revealed through a fragmented and discontinuous process.

In order to capture data in this complex process, where research and practice are occurring simultaneously, each group was taped and transcribed. There were 104 groups lasting one and a half hours and ninety reflective action cycles identified in the course of these groups. In addition, other data was collected, as described below.

Field notes

Following each group there was a discussion between the group facilitators and when possible, the group supervisor in order to reflect on the group processes. Notes were kept on what we felt we achieved, the key themes emerging from the group, the group dynamics themselves, what we felt we had learned and how we could structure the next session.

Reflexive Notes

Having engaged as a participant researcher with nurses in the previous project (Croom 1996, discussed in Chapter Five), I had already developed practice data related to the potential devaluation of nurses because 'care' was not articulated in the dominant language of psychology and psychiatry. As a researcher, I was also both a nurse and mother and acknowledged therefore that I could not be neutral to the power of care nor to the potential oppression and devaluation of carers. It was necessary therefore to use both the literature and the external supervisor as means to critique my values and interpretations. On a weekly basis, I kept my own reflexive notes of how I felt in the session and so did the co-facilitator. We then shared these at the end of the group session and also in supervision. The reflexive notes also served as a check to ensure that we shared with the parents, the content of parenting programmes derived from the evidence base (Cunningham et al 1995, Webster-Stratton 1998) but also provided them with the nursing knowledge from the previous research discussed in chapter 5. In this way, we could ensure that the parents were receiving a quality service, as defined by the evidence base, plus the nursing knowledge from the previous research. In addition, the iterative process, which was found to be useful by the nurses in the previous study, discussed in chapter 5, was continued with the parents. The parents'

experiences were continuously compared to further literature by the group facilitators to explore if there were any further insights could be gained. The parents were then given access to this literature to explore if they found this additional information useful or not in their everyday care.

Data from the application of critical theory within the action research paradigm

The facilitators used field notes and reflective action cycles from the transcribed data to identify (as far as possible on a weekly basis) any underpinning societal assumptions/norms/ knowledge, which appeared to enhance or constrain the process in which the parents could develop new solutions or improve their knowledge and skills (see findings). We then checked these out with the group at the following session and encouraged discussion on the potential for challenging these assumptions.

Making sense of the data

In many ways the issues confronted and addressed in this research reflect the concerns and issues raised by Meyer (1995) in an earlier study. Meyer was concerned to undertake action research into the introduction of lay participation in care in a hospital setting. Meyer drew on McNiff's (1988) work that recognised that formal models of action research tend to be concerned with observation and description rather than explanation and as such are not educational in themselves. In contrast, McNiff (1988) stresses the need for practitioners to be able to formulate their own personal theories based on practice. McNiff (1988) suggests that research needs to have a self-generative capacity to allow for the more creative spontaneous episodes which occur in reality. She therefore proposes a 'generative action research' which enables the

practitioner to address many different problems at one time without losing sight of the main issue. This idea of addressing many different problems at one time resonates with the experience of this research which required us to pursue rigour in the midst of the fluidity of clinical reality.

McNiff (1988) addresses this problem through the use of a three-dimensional spiral of action-reflection cycles, and it is this which, in some ways, best describes what happened in this study. This reflects Meyer's (1995) experiences of action research. She too took a conscious decision not to use a more prescriptive model as she wanted to take on a facilitative role and allow issues and problems to be dealt with as they emerged naturally from practice.

Although a protocol was drawn up (Appendix 11) to ensure that each cohort had access to the nursing knowledge and skills and the evidence base on parenting programmes, this was flexibly applied according to the needs of the group and the issues raised. Thus, the group processes were allowed to evolve naturally with a focus on the educative, reflective, clinical and therapeutic outcomes. To achieve rigour, the field notes taken by the facilitators and tape recordings were subjected to the cyclical process of action-reflection spirals, as discussed by Meyer 2000.

Additional analysis was achieved through the application of critical theory by analysing the transcriptions and field notes to identify (as far as possible on a weekly basis) any underpinning societal assumptions/norms/ knowledge, which appeared to enhance or constrain the process in which the parents could develop new solutions or improve their knowledge and skills (see findings).

In many ways, this represents the assessment stage described by Meyer (1995). At the next group the reflective analysis of the data collected at the previous group session undertaken by the researcher and group facilitator, were checked out with the group participants who were encouraged to discuss the potential for challenging these assumptions. New behaviours were identified and the parents were encouraged to try these out during the following week (action stage). This was reviewed the next week and the lessons learnt discussed (evaluation stage) which could also give rise to further action or assessment and action and evaluation in an on-going reflective action cycle. The following critical incident provides an exemplar, which illustrates how critical theory and reflective action cycles were combined in the data collection.

Critical incident 1 to illustrate how the methods were combined

In session 4 of cohort 1, parent 1 discussed how “useless and humiliated” she had felt on her last visit to the school, when she was collecting her child at the end of the day. She described how the teacher had asked to see her and in front of the other parents and within their hearing, had taken her to one side to tell her that her son had been very disruptive in class that day and had been constantly getting up and walking around, eventually annoying the other pupils and leading to his having to spend time outside of the head teacher’s office. The parents in the group discussed how they all felt as if teachers perceived them to be unsuccessful in socialising their children and judged them according to a “given set of norms” (such as in this case, “all 8 year old children should be able to sit still in class once this rule is explained”) and this made them feel as if they were “bad” parents. The group then engaged in the application of critical theory through critical discussions to challenge whether it was legitimate to apply the same set of norms to all children. Parents felt strongly that

children should be treated as individuals, so that their individual needs can be met. After being given access to the nursing knowledge, two of the parents identified that they felt that the nursing knowledge related to information processing was helpful in explaining their child's needs and their difficulties of thinking of processing information when frustrated in a way, which enabled them to meet their goals and stay out of trouble.. The parents then discussed how applying the literature on information processing helped them to understand how their children's difficulties with attention meant that they often needed to have their work explained more than twice. The group felt that explaining a child's information processing difficulties to their teacher may help the teacher to move from a position of "all children should listen first time" to "some children may need extra help with listening". Parent 1 undertook to try this out for the next week. In the interim, the researcher and facilitator explored the literature to see if any additional insight could be gained. The research on temperament appeared to be potentially helpful in further explaining the natural variation in children's responses to social situations and norms. This was shared with the parents at the following session. Parent 1 reported that she had found the information processing knowledge helpful in discussing the child with his teacher and all of the parents felt that knowledge on temperament provided an even greater insight.

We then asked the parents to explore what difference it could make in their everyday lives if they actively challenge the prevailing assumptions and beliefs, which impacted on their children. The parents were also consulted about the changes to the "status quo", which they perceived were necessary in order to apply the findings from this research. This enabled the group to discuss parenting as a societal issue rather than

an “individual issue”, which lead to individuals being blamed. However, at a subsequent week, another parent found that the teacher did not listen when she attempted to explain her child's needs. This provided a challenge to the usefulness of sharing knowledge on temperament and information processing with significant others such as teachers and promoted a refined understanding that knowledge and skills alone were not sufficient to create social change.

The iterative inductive analysis with the parents of the nursing knowledge and skills/ propositions and further literature thus produced data on how the parents developed and refined an iterative set of insights into the knowledge and skills parents found useful in their everyday lives. Data was also produced on the opportunities and constraints for change, which could arise from supporting parents as individuals to critique the dominant ideology.

Sampling the Data and data Analysis

The above example illustrates the difficulties of extracting discrete critical incidents for analysis from what was essentially a developmental and learning process. This created considerable challenges to the analysis of the data. However, the above example also illustrates how the parents engaged in a full reflective cycle (Diagram 1) first proposed by Lewin (1948) and developed in research such as (Rolfe 1998a) and Khanlou (2004

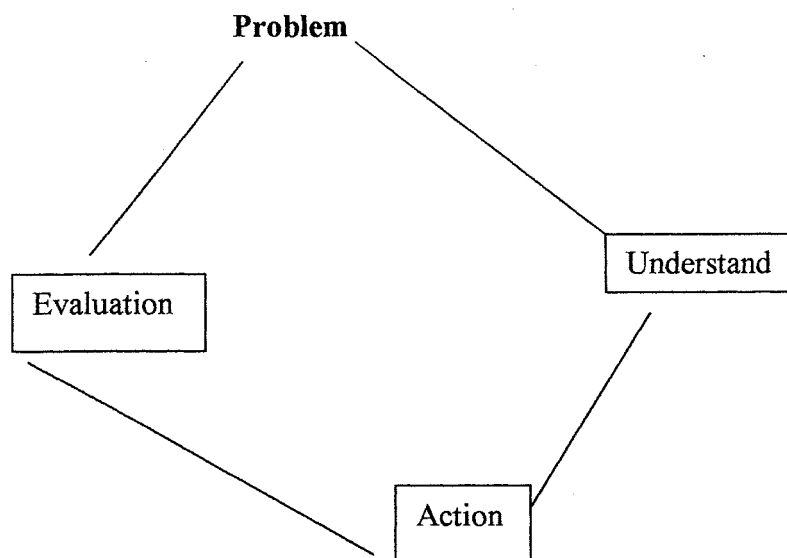


Fig 1: Reflective Action Cycle

This basic action research cycle in diagram 1 is further developed in Figure 2 opposite page 188 to illustrate how the above action cycle was used in this thesis to collect and analyse data whilst simultaneously delivering a clinical service.

As only 50 of the parents out of the 70 parents invited to participate agreed to attend and of these 45 attended the first session, the data, consisting of the full reflective cycles could only be collected from the 25 parents who attended at least 75% of the group sessions and who therefore engaged as participant researchers in the research process.

The process of data collection and data analysis were thus achieved together through the use of the reflective action cycle. In the research, the overarching problem was how to care for children with challenging behaviours over a 24 hour period. In the course of the research, the parents brought along a range of issues and an incident related to the child's challenging behaviours. As a group, we then explored how they could be understood. Further understanding was achieved through analysis of the

transcriptions. After each session, the tape was transcribed by the researcher, who then analysed the transcription of the sessions on a weekly basis for reflective action cycles and the emerging themes /patterns within these cycles which demonstrated:

- (1) Evidence, which supported the usefulness of the nursing knowledge and skills to the parents
- (2) Evidence, which refuted, refined or developed the nursing knowledge and skills
- (3) New themes, which represented additional knowledge and skills arising from the parents' experiences
- (4) Any themes, which represented unresolved issues related to the management of children with behavioural problems. There was then a search in the literature to discover if any additional literature in the evidence base may be helpful to the parents.
- (5) Checking out that the reflective cycles were not being produced by any one parent or subgroup from week to week.
- (6) Consistency across the groups in the findings

The facilitators thus used the transcriptions to reflect on the action of the group processes. Through reflection in action, within their own context, the parents then tested out the relevance of the information when applied to actual care of their child. Both the parents and the facilitators were then able to evaluate their actions through joint reflection on action in the following group session.

The following example provides an illustration of how the data was iteratively analysed.

Parent 2 in cohort 4 brought an incident, which had severely distressed her in the previous week. Her child had kicked his sister, when she asked him to come for his meal. The mother had had a difficult week in which she had been worrying about the electricity bill and her son had been in trouble at school. She described how seeing her other child upset had caused her to 'lose it' with her son. Her initial interpretation of the situation was that the child was deliberately winding her and his sister up. The other parents empathised with this and shared how they also felt that their child deliberately wound them up and how angry it made them. This joint understanding and empathy in the group helped the parents to explore this further and they also identified that they felt helpless at being able to change it. Introduction of the action component of the action research i.e. the nursing practice framework (appendix 1) and further literature on temperament, (derived from previous action

~~cycles in this thesis) helped the parents in the group to consider alternative~~
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emotions arising from his dislike of change and so cognitively process how he was going to deal with leaving his current activity and come to the meal table. The parent agreed on an action plan to try giving a transitional warning, as suggested by Cunningham et al (1998) and to let her child know ten minutes before a change of activity e.g. that his meal was ready and then 5 minutes and to monitor this for the following week. The other parents also agreed to apply this in their community context and discuss it the following week. Following the group, the session was transcribed and compared to the evolving knowledge, skills and theory derived from previous action reflective action cycles in previous sessions and cohorts. Two themes emerged from this transcription. One was that the parents identified how difficult they found staying emotionally neutral, when their child was challenging, because of the other psychosocial stressors they suffered. This seemed to lead to a feeling of helplessness. However, they felt that access to the information from the nursing skills and from the parenting literature helped them to tune into their child and seemed to empower them to see how they could act differently. A second theme was the social pressure they felt under to interpret that their child was naughty. At the following group, the parents fed back their evaluation of the action plan and the facilitators checked out the themes, which appeared to emerge from the transcription. The parents evaluated that the effectiveness of engaging in transitional warnings depended not only on the parents gaining the knowledge on temperament and information processing and parenting literature, but also on the parents' emotional capacity to be able to calmly analyse the situation and to apply the solution i.e. the transitional warning in a neutral way. This led to an exploration of the themes arising from the transcription and to analysing the factors, which impacted on the emotional capacity of the parents to care for and provide effective responses to their children,

when they presented with challenging behaviours. Over a series of weeks, this incident was discussed several times and a range of variables were identified, which affected the capacity of the parents to handle such situations in an emotionally neutral way. These included socio-economic factors and housing factors. The parents also reflected further on the social pressure they felt to interpret their child's behaviour as naughty, rather than see their child as a child with difficulties. They felt that the information on temperament and information processing did help them to challenge this perception of their child's 'naughtiness'. However they felt that all carers and professionals should have access to the information, not just parents. They also challenged the facilitators to disseminate this more widely, for example, to GPs and teachers. The facilitators had to reflect on the hegemony of professional knowledge among CAMH professionals and to raise their awareness of their role in perpetuating this in order to change their practice.

The above example illustrates the process of data analysis and how the evidence base/ deductive framework of the nursing knowledge and skills was iteratively tested out through the reflective action cycle. There was also a simultaneous refinement of this knowledge and an iteratively evolving set of themes. These themes helped to develop theory grounded in the parents experiences on what kind of information in which circumstances was helpful to the parents' capacity and the psychosocial factors, which offered opportunities and constraints to the parents capacity to be able to apply this knowledge in their context to meet the child and family needs. Both the theory and the themes were subject to ongoing analysis for both consistency of patterns and also changes in patterns through the 12 sessions of each cohort and also across the cohorts.

Diagram to illustrate how data was analysed through reflective action cycles.

Identification of practice problem

Selection by parent of critical incident, which is an experience which was significant because parents felt that it represented behaviours that worked particularly well or not so well in caring for their child.

Identification of practice problem that needs to be solved or how to disseminate experiential knowledge

Data Analysis: Problem themes identified: guilt, isolation, frustration at not being able to get help, problems with child's school, child not listening, feeling out of control as parent

Data Analysis: Refinement of knowledge and skills:

1. Parameters of relevance of nursing knowledge and skills in community context
2. Knowledge on how to cope with potential oppression

Iterative evolution of practice framework incorporating:

- i) Refinement of propositions
- ii) New themes emerging from experiential experiences of parents
- iii) Additional literature which is found to be useful (e.g. temperament)
- iv) What parents can teach professionals
- v) Capacity for increasing potential of parents and professionals and services to respond to children with disruptive behaviour problems

Understanding of Practice problem

1. Reflections by group on knowledge and skills manifested and potential solutions to difficulties.
2. Reflection of group on incident when given access to nursing skills and knowledge/other literature sources related to parenting incident, such as traditional parenting program approach of Cunningham.
3. Reflection by group on their perceived relevance of additional information to the management of this incident and similar incidents in their own experiences.

Themes identified in terms of increased understanding of parents: increased understanding of how to tune into child and how this can help parents to stay emotionally neutral

Increased understanding of facilitators: Impact of psychosocial stress on parents' capacity to be emotionally available to child and to utilise new knowledge

Evaluation

1. Evaluation from parents of how useful new knowledge/group generated solutions were to them in their context.
2. Evaluation of how accurate the themes from transcriptions were when fed back to group.
3. Evaluation impact of any potentially oppressive assumptions that have emerged and how these can be changed

Data Analysis:

- *Identification of knowledge useful in practice*
- *Theory generation on psychosocial factors and sources of oppression that constrain capacity to implementing new knowledge and impact on capacity*

Action

1. Discussion by group on how the solutions can be applied to their community context
2. Testing out this solution in their actual community context. (reflection in action)
3. Transcription of group discussion:

Identification of themes and analysis of emerging themes by researcher.

Data Analysis: Identification of solutions arising from increased understanding and their exploration of what they would find useful with their child e.g. how to apply this in parents' context e.g. do a study of their child, give transitional warning, acknowledge awareness of their ambivalence, challenge oppressive assumptions by changing their own beliefs, going into school and challenging ideas that all children should be treated the same or challenging sense of blame from neighbours

Iteratively evolving Practice framework

1. Synthesises themes emerging from data analysis.
2. Provides tentative framework of knowledge and skills, which can be generatively explored and iteratively revised
3. Provides action plan, which is grounded in participant action research with parents

Figure 3 (opposite page 193) provides an illustration of the data analysis cycle and how it conforms to the classical action research cycle.

In the findings, exemplars of these cycles are provided to illustrate the data collection and data analysis process. In addition, detailed data is presented from the reflective cycles in the findings chapter, in order to identify the findings of the inductive analysis of the nursing knowledge i.e. when the parents found this knowledge useful, when it was not considered useful and when the parents could refine it. Because of the collaborative and iterative analysis between group sessions and group cohorts, the data analysis was an ongoing collaborative process with the parents.

Appendix 11 summarises the protocol used to simultaneously deliver a clinical intervention (access to the nursing knowledge and skills and to Cunningham's programme), engage in the research process in which there was a participative inductive analysis of the propositions derived from a deductive framework of knowledge, and to iteratively develop a cumulative body of practice knowledge and facilitate practice change through the reflective action cycle.

This process was repeated in each group session of every cohort, so that there was an iterative analysis of the nursing knowledge and skills and the literature and a dynamically evolving body of cumulative practice knowledge grounded in the parents' experiences, which could inform practice change. If a new theme or refinement emerged in a cohort, the transcriptions of the previous cohorts were re-examined to explore whether the theme was also relevant to other cohorts, although it may not have been picked up at the time or whether there was data to challenge the evolving practice theory. The new or refined theme was then shared with subsequent

cohorts. The process was repeated until the parents had had the opportunity to access all of the nursing knowledge arising from the previous study and also had access to Cunningham et al's (1998) evidence based programme and any other literature, which the facilitators found was of potential relevance to understanding the emerging problems and issues identified through the analysis of the parents' experiences.

Evaluation of changes in parents' perceived behaviours and understanding as a result of engaging in the practice research.

The evaluation was a collaborative process and consisted of both the evaluation component of the reflective action cycle and also a short questionnaire (Appendix 8).

As part of the reflective action cycle, the parents evaluated the impact of the access to nursing information and skills on their understanding and their capacity to develop and implement action plans. Evaluation from the field notes and transcriptions were checked out verbally with the parents on a weekly basis and also in the last group session of each cohort.

Parents were asked to complete the short questionnaire (appendix 8) at the beginning and end of each cohort. Findings from the questionnaire were triangulated with the parents' ongoing weekly verbal feedback and also verbal evaluation from the final session in each cohort. The questionnaires were only included for the 25 parents who actively participated as researchers by attending 75% of sessions and engaged on reflective action cycles. These 25 parents also attended the first and last session of each cohort. The questionnaires from all of the 45 parents who attended the first

sessions were analysed and were not found to differ in themes or content to the 25 actively participating parents.

The final data set and analysis were presented to the external supervisor and to two peer groups of nurses for further peer group audit.

Summary

This Chapter has described the process of data collection and analysis used in this thesis. It has presented an honest account of the difficulties encountered in using clinical data and clinical processes as research data and the difficulties encountered in separating the two. It has highlighted the importance of locating the self in the data collection and analysis process. In doing this, it has demonstrated how the clinical processes used in the research arose out of a personal critique of the established evidenced-based approach to parenting groups. It has also demonstrated how critical theory can be combined with other research processes, in particular critical incident technique and the action-reflection cycle to simultaneously enhance clinical care processes and provide a method to engage in data collection and analysis.

It was acknowledged at the outset of this research that one of the difficulties of engaging in practitioner participative action research with clients whilst simultaneously delivering a service is how to differentiate the research data from the clinical data for the purposes of data analysis, when engaged in research. However the thesis provides a potential solution to this through the use of completed action research cycles. This means that the totality of data collected was purposively sampled to identify those critical incidents in which the reflective cycle including

action by the parents in trying out the knowledge gained from the group, formed the research data analysed in the findings chapter. Only completed action-reflection cycles were incorporated as research data. This links to the focus on the 25 participants who attended 75% of group sessions as only they engaged sufficiently with the groups to complete the action-reflection cycle. The focus on the completed action-reflection cycle provides a method for using critical social theory in a practice context. As discussed in the previous Chapter, critical social theory is concerned not only with '*what is*', but more importantly with '*what might be*'. This emphasis is central to the development of knowledge designed to empower people whose voices are normally silenced. It was, therefore, necessary to focus on completed action-reflection spirals if the principles of this method were to be adhered to.

Clearly other data and incidents were collected, but if the parents didn't return to the group and no further data were available it was not possible to speculate on the implications of this for the findings. The process of purposively sampling clinical data for completed action-reflection spirals in order to demarcate research data from clinical data appears to be a novel approach. The strengths and limitations of adopting this approach will be discussed in more detail in the discussion chapters at the end of the Thesis.

There are a wide range of other research questions that this thesis could potentially have addressed, including why people failed to return or whether there was anything different about the uncompleted as against the completed action cycles, but these questions, although valid and interesting, did not form the focus for this research, although they are important research questions for future research.

The findings chapter provides an analysis of the 90 complete action-reflective spirals which comprise the data used in this thesis.

Chapter 5

Background to thesis: Discussion of nursing research which the thesis is building upon.

This Chapter provides an overview and critique of the MSc nursing research study (Croom 1996) from which this thesis evolved. The MSc study used the work of Walker and Avant (1988) to develop a concept analysis of the concept of 'control'. This was combined with qualitative data analysis derived from critical incidents and actual practice situations brought to the research by nurses working in an in-patient CAMH unit, to produce a framework or conceptual structure to inform this aspect of nursing practice.

Background to the MSc Study

The MSc study focused on developing 24 hour nursing knowledge and skills for caring for children with the types of challenging behaviours described in the literature chapter, and it involved participant action research with experienced nurses working in a regional, residential child and adolescent mental health unit (Croom 1996, Croom et al 2000). Nursing practice in the unit had evolved over a period of more than thirty years. All registered nurses at the unit completed a multi-disciplinary diploma in Child and Adolescent Mental Health (CAMH) and had the opportunity to attend a range of in-house seminars. The Unit has an international reputation as a centre of excellence in medical research in CAMH. However, the body of CAMH *nursing* practice knowledge and expertise (which was related to 24 hour care) remained at an intuitive/informal level, in contrast to psychology and psychiatry knowledge, which

was either published or underpinned by articles published in prestigious journals. The strong research culture underpinning psychology and psychiatry enabled the psychologists and psychiatrists to articulate and disseminate their knowledge and skills. Consequently, their language and perspectives tended to dominate the interpretation of the child's progress in the unit, although the nurses provided the 24 hour care.

At the beginning of the research, the nurses reported that they frequently perceived that other professionals were ascribed more power and legitimacy than they were as nurses, particularly in multi-disciplinary assessment and planning meetings. However, as psychology and psychiatry focuses on providing episodic therapeutic sessions rather than in the provision continuity of care, the nurses recognised that there was a practice/theory gap in the formalised body of knowledge and skills related to supporting children with emotional and behavioural problems throughout the 24 hour care period, the nurses agreed to engage in action research and to act as participant researchers to attempt to identify the skills and knowledge they used to carry out this activity.

Following a small group discussion early in the nursing study (Croom 1996), the nurses identified that a critical practice problem for them in providing 24 hour care was to help children with disruptive behaviour problems to develop a sense of "control", which enabled them to cope with everyday frustrations without either becoming a danger to themselves or others or interfering with their capacity to meet their social, emotional and developmental goals. However, when the nurses started to explore the concept of control, they found that it was ill defined, fuzzy and

ambiguous (Croom 1996, Croom et al 2000). As one experienced nurse in the Croom 1996 study explained:

"We're always talking about whether a child has developed inner control or not, but what does that really mean... You're trying to help them achieve a sense of control but there's nothing really written down, no guidelines which say if this fails do this. It's like a magician pulling something out of a hat and you hope you're going to achieve a happy medium which is acceptable to the child, yourself, your colleagues...the lawyers" (Croom 1996)

The lack of conceptual clarity and the poor articulation of associated practice knowledge and skills related to control was further illustrated by the Department of Health (1992) guidance "Permissible forms of control in residential care", which the nurses were expected to implement. This DoH document recommended that the practitioners should identify when a child is in danger of losing control in order that they take preventative action. However, the actual practice knowledge/skills, which could guide how residential carers could identify, assess, prevent or manage situations in the 24 hour life-space of the child, when children/young people had problems with self control, were not described. This reflected the nurses' discussion of this aspect of their practice in which they recognised that they were asked to achieve control but that the skills and knowledge required to carry out this task in practice had not been identified.

The focus on control as a key aspect of practice in providing the continuity of 24 hour care for children with challenging behaviours, was supported by the literature. For

instance, Caspi et al (1995) found that early lack of control was associated with the development of externalising behaviours in later childhood. Wenar (1983) argued that self control features more prominently than any other variable in psychopathologies and when excessive, it lays down the foundation for neurosis and when weak for antisocial behaviours. The achievement of personal control is a critical component of achieving other social and emotional tasks (Erikson 1959). More recent evidence identifies that helping their child to develop control is also a significant issue for parents (Cunningham et al 1995). Despite this, at the beginning of the nursing study (Croom 1996), there appeared to be a real practice gap in the identification and explication of skills and knowledge, which can help both professionals and carers to support children to develop age appropriate control in their everyday context.

The nurses also identified that not only was the concept of inner control poorly defined but also that the set of nursing knowledge and skills which they used to support children, who found it most difficult to develop a sense of control in a 24 hour practice context were difficult to articulate because they were mainly located at an intuitive level. In order for the nurses to access, interrogate and articulate their taken for granted skills and to cumulatively build on these, a combination of methods were required. Concept analysis (Walker and Avant 1988) was combined with critical incident technique (Smith and Russell 1991) and analysis of actual practice situations to develop a practice theory of control.

Concept Analysis

Concept analysis is increasingly being used in nursing and midwifery research as a method for defining complex, messy and ill-defined aspects of practice prior to theory building (Morse 1995). The term concept analysis was entered into the Cumulative Index for Nursing and Allied Health Literature and produced 720 articles. In 2004, forty three articles from a range of different countries were published in which concepts were analysed using formal methods. These included bereavement support (Nallen 2004), preceptorship (Billay and Yonge 2004), aggression (Liu 2004), compliance (Rioux and Sylvain 2004), forensic risk (Kettles 2004), threat (Ritchie 2004), dignity in older adults (Jacelon et.al. 2004), health related quality of life (Stredl 2004), risk (Shattell 2004), health promotion and health education (Whitehead 2004) practice development (Hanrahan 2004), functional status (Wang 2004) coping and stress (Keil 2004) autonomy and adolescence (Spear and Kulbok 2004) psychological distress (Ridner 2004), cultural competence (Suh 2004), spirituality and child development (Smith and McSherry 2004). These articles illustrate the range and scope of the method of concept analysis found in the contemporary nursing and allied health literature.

Concepts have been described as the building blocks of theory (Chinn and Jacobs 1983). Morse et al (1995) has highlighted the importance of developing conceptual clarity as a foundation for theory development in clinical practice. She highlights how the biobehavioral synthesis of the nursing perspective requires nursing to adhere to the standards of the social sciences as well as to those of the physical sciences. As a result, nursing as an emerging discipline, has been forced to attend to principles of

philosophic inquiry as well as to epidemiological concerns; to attend to micro and macro perspectives; and to attend to the cell, the person, and the community. It is within this context that importance has been attached to delineating concepts in nursing research.

The use of concept analysis in nursing can be traced back to the work of Wilson (1963) who advocated the analysis of hypothetical cases in order to derive the defining attributes of a chosen concept. Wilson's work was developed by Walker and Avant (1988) who propose a structured series of steps for concept analysis which includes searching a wide range of literature, thesauruses and dictionaries to identify as many different uses of the concept as possible prior to deriving the attributes of the concept. Rodgers (1991) has criticised the approach to concept analysis advocated by Walker and Avant, suggesting that the construction of multiple cases early in the concept analysis is too rigid and produces a superficial analysis which does not aid theory development. Rodgers advocates a more evolutionary approach, which includes qualitative data on the manifestation of the concept in real life situations, rather than relying on hypothetical cases (Rodgers 1991). He recognises that the concept may evolve over time and allows for this in his method of concept analysis.

Keil (2004) also cautions against the approach advocated by Walker and Avant (1995) suggesting that it is too inclusive. Keil points out that at an etymological level a concept may have two distinct meanings. Keil discusses the example of coping given by Walker and Avant (1983). In examining the concept 'coping', Keil suggests Walker and Avant include uses of the concept derived from two entirely different words. "Etymologically, the word cope₁ ('₁' indicates primary meaning, as in 'She coped with the problem') derives from the Latin *colpus* – a blow, via the French *couper* – to cut. Its primary meaning of hitting or cutting then produced secondary

senses of *contending with* and finally *overcoming*. It is etymologically quite distinct from cope₂ ('₂' indicates secondary meaning) a priest's cape or vestment, from medieval Latin *cappa*. For this reason, the concept 'cope' (as in 'cope with a problem') does not include senses of 'cover' or 'protect' – elements which are derived from cope₂ and not from cope₁. The difference is important, as failure to distinguish between two different words leads Walker and Avant to put forward as a paradigm an instance which is, in fact, entirely outside the range of the concept" (Keil 2004, pp.659). Cahill (1996) is concerned about the linear approach proposed by Walker and Avant (1983) suggesting that the process of concept analysis is more discursive than their method would suggest.

The concerns raised by Rodgers (1991) Cahill (1996) and Keil (2004) highlight the importance of being clear about setting the parameters on the meaning of the word at the start of the research but also of introducing practice examples into the analysis to ground the data in the complexities of practice.

Morse (1995) is one of the foremost proponents of concept analysis in nursing. She adheres to the approach proposed by Rodgers (1991) and agrees that the method developed by Walker and Avant (1988) is too rigid resulting in a superficial analysis of the concept which does not progress theorization. She also advocates the use of clinical data in concept analysis. Morse and Doberneck (1995) suggest that the cardinal rule in concept development is that the conceptual components (i.e. attributes) identified must be common to every particular situation to which the concept applies and is used. She highlights the dimension of universality that accompanies concept analysis pointing out that "while the abstract components that form the concept must be present in each situation in which the concept is utilized,

these components will be influenced by context so that the same concept might not appear identical when used in two different situations” (Morse and Doberneck 1995).

Morse and Doberneck (1995) go on to suggest that “Once the abstract and universal components of the concept are identified, these represent the tentative structure i.e. a type of "framework"-that constitutes the concept. Verification of components is achieved by searching for indicators of these characteristics in other situations or in other populations, in which the concept appears. Thus, in this deductive phase, other data are searched for similarities and commonalties that fit into the inductively derived "framework." It must be noted that while the original framework is derived from one exemplar, in the second "testing" phase, examples of these components are sought in other databases and in other situations. Therefore, if the original characteristics are incorrect and do not "hold," they need to be revised. When this occurs, going back to the first step (using another exemplar) is required. The original components are modified, or the framework is revised (Morse and Doberneck 1995, p. 278).

Morse and Doberneck (1995) along with most contemporary researchers using concept analysis combine a search of the literature with qualitative data including clinical incidents and professional experience. As they point out “in these instances, qualitative research methods provide a means for delineating, clarifying, comparing, and modifying concepts. The use of data to develop concepts, provides a basis for developing solid, significant, and clinically-based theory” (Morse and Doberneck 1995, p.278.).

The aim of a concept analysis is to clarify the meaning of a particular concept through the use of a particular approach or strategy (Walker and Avant 1988). In the masters study, the nurses had identified that they found 'control' to be a key practice concept, but that it was fuzzy, ill defined and ambiguous. It was acknowledged within the study that concepts are only constructions or mental images about a thing or action. However, it is essential to define the parameters of concepts since they are the basis for theoretical perspectives and research designs (Morse 1995). The parameters of the concept analysis of control in the nursing study upon which this thesis builds, were bound by nursing knowledge and practice of child and adolescent mental health and contextualised within the residential unit in which the research was carried out. It was thus acknowledged that the concept analysis was not attempting to present a definitive reality, but rather to be used as a platform upon which to further refine and develop practice knowledge and skills by organising a range of environmental stimuli and identifying how experiences are similar and categorising the elements that are alike into a group (Walker and Avant 1988).

The nursing study (Croom 1996) upon which this thesis builds, utilised Walker and Avant's (1988) approach to concept analysis. However in recognition of the limitations of this approach described above, it was combined with critical incidents and actual practice situations to further the development of the concept as a basis for theory generation in nursing as described by Morse (1995).

Thus, in the nursing study, a concept analysis of control was undertaken using the eight step method developed by Walker and Avant 1988. These eight steps consist of:

1. Select a concept
2. Determine the aims or purposes of the analysis
3. Identify all of the uses of the concept that you can discover (in the literature)
4. Determine the defining attributes
5. Construct a model case
6. Construct borderline, related, contrary and invented cases.
7. Identify antecedents and consequences
8. Define empirical referents.

These steps will now be discussed in more detail:

Select a concept - The concept of control was selected because the nurses identified that this was a key area of practice, which required clarification when working with children with challenging behaviours.

The **aims of the concept analysis** were to identify the critical attributes of the concept of control, through the concept analysis process and then inductively analyse these attributes with the nurses for their relevance in the nurses actual practice context.

Discovering the uses of the concept of control was achieved through a broad search of the literature. Control was entered as a key word in CINAHL and PsycLit as well as dictionaries and thesauruses in order to identify the range of different uses of the concept of control. The concept was found extensively in the nursing and allied health literature and the PsycLit and dictionaries and thesaurus identified the use of the word in other disciplines such as engineering and physics. The different ways in

which the concept was used in each of these literatures were identified and the defining attributes derived.

The defining attributes of control are the 'characteristics of the concept, which appear over and over again (Walker and Avant 1988:14) In order to refine this further, within the practice context, a model case, a borderline case and a contrary case were constructed, following the method of Walker and Avant 1988) A model case, is a real life example of the concept in which all of the critical attributes are present. A borderline case is an example of the use of the concept in which some but not all of the attributes are present. Constructing borderline cases helped to clarify what the concept is similar to. A contrary case helps to clarify what the concept is not.

The antecedents and consequences of the concept of control were then identified. According to Walker and Avant (1988) "antecedents are those events that must occur prior to the occurrence of the concept" (Walker and Avant 1988, p. 45). The antecedent to developing a sense of control for children was identified as a trusting attachment relationship, in which the child could be supported to develop strategies to regulate their emotions and the motivation to please the carers by adopting those strategies in appropriate situations. Consequences are "those events or incidents that occur as a result of the occurrence of the concept" (Walker and Avant 1988, p.45). A consequence of developing a sense of control was identified as a sense of competence.

The final step in the analysis, according to Walker and Avant is to define the empirical referents of the concept. Empirical referents "are classes or categories of actual phenomena that by their existence demonstrate the occurrence of the concept

itself". (Walker and Avant 1988, p. 46). The empirical referents for control in a CAMH context were identified as:

Evidence of a previous attachment to a care giver

Ability to deal with stress without disintegrating into socially or individually harmful behaviour

A pause or time lapse when confronted with stress to allow immediate and relevant information to be processed

An ability to deal with information i.e. to perceive information, attend to it, remember experiences.

An ability to learn from expertness

An ability to internalise rules

In the masters study, it was recognised that the concept of control is usually recognised in individuals by behaviour in which an individual can demonstrate that he/she can stay calm enough to meet a certain social, emotional or physical goal in the face of frustration or stress.

Following the formal concept analysis as described above, the critical attributes of the concept analysis were applied to practice as advocated by Morse (1995). The attributes shared with the nurses, who were asked to analyse to what extent the empirical referents and the literature underpinning them were useful to them in helping them to gain insight into and effectively manage episodes, where children with challenging behaviours lost control or were in danger of losing control in a way

that prevented them from meeting their personal, social or developmental goals or that could cause danger to themselves or others.

Critical incident analysis (Smith and Russell 1991) was used to capture authentic practice data. Wilson and Fish (1993) proposed that critical incident analysis has particular effectiveness when the important dimensions of performance have not been identified and where the goal is to alter behaviour in the direction of more effective performance. In the case of the nurse's research (Croom 1996), this involved attempting to identify the critical skills involved in helping children with behaviour problems to improve their self control. Norman and Redfern (1992) modified the technique to access 'happenings', which are meaningful to the respondent and identified that "by capitalising on the respondent's own stories, critical incident technique potentially avoids the loss of information which occurs when complex narratives are reduced". The analysis of data from real incidents in the nurses' experiences, helped to generate authentic data, upon which to carry out the inductive analysis of the literature.

In the nursing study, critical incidents were defined as incidents, which the nurses felt were meaningful because they felt that they had gone particularly well or not so well in effectively supporting a child with behavioural problems to maintain or re-gain control. In this way, authentic practice data with identifiable processes, consequences and outcomes was made available for analysis.

The concept analysis thus served to synthesise a range of theoretical perspectives on control and was then used as an heuristic device to help nurses in a CAMH context, to

investigate their taken for granted nursing practice and everyday experiences in order to help them to identify their taken for granted assumptions, tacit knowledge and skills. Using the concept analysis as an heuristic device enabled the nurses to critically explore how the published literature, identified through the concept analysis, related to 24 hour nursing care. As a result of this process, a body of practice knowledge and skills began to emerge, which was grounded in both nursing practice as demonstrated through the critical incident and the literature included in the concept analysis. The critical incidents were analysed using group discussions among the nurses and the concept analysis modified in the light of the critical incident analysis as suggested by Morse (1995). This process was repeated a number of times in an iterative cycle of refinement and development. The knowledge and skills identified through this process were then developed into a practice framework (see Appendix 1), which the nurses found was useful in enabling them to use existing literature to systematically assess and respond to children with challenging behaviours. The framework was not seen as a definitive product, but as a platform, which could generate further insights and practice based research in the iterative development of nursing knowledge and skills.

Developing the MSc research on control as a foundation for the PhD thesis

Morse (1995) has described the lengthy and detailed process required to move from concept analysis to the development of clinically based theory in nursing research. She highlights the importance of clearly delineating each step in the process and of combining deductive and inductive processes to produce adequate accounts of nursing knowledge which are sensitive to the individual characteristics of the situation but which draw on the wide range of knowledge available to inform practice in that

situation. In this section of the Chapter, the analytic process used in the MSc thesis is described to identify the foundation for the propositions derived from the nursing knowledge which were then tested with the parent population in the PhD thesis.

According to Morse and Doberneck (1995) the final step in concept analysis involves comparison of the components of the concept, as manifest in other situations and with other populations. Data from each group is compared component by component to elicit different forms of the concept. While the abstract and universal components of the concept remain, they need not be manifest identically in each group. While the concept may apply to each situation at a general level, the unique conditions in each group, situation, or context will modify the concept and give it a particular pattern or typology, and these variations are then identified and described. Furthermore, the "unique conditions" within each sample that contribute to variations must be identified. According to Morse and Doberneck (1995) it is this phase of analysis that enables rigorous theory development and makes the results.

One of the problems of concept analysis which has been repeatedly identified is the overlapping of concepts and the slurring that can occur from one concept to another Walker and Avant (1995) deal with this problem by describing related concepts which often share some but not all of the defining attributes of the key concept. The need to combine concepts to develop nursing knowledge is increasingly recognized. As Morse and Penrod (1999) have identified "The mechanics of qualitative research, the vast amount of knowledge available, and the technical management of data usually force qualitative researchers to focus on a single phenomenon or concept. Yet the nature of reality and the holistic perspective of nursing demand that eventually it be acknowledged that concepts are interrelated. Methods that acknowledge conceptual

co-occurrence should be developed. Current quantitative methods permit the relationship and association of concepts to be examined sequentially and concurrently, and qualitative methods are being identified that assist with the identification of the interrelationship among concepts (e.g., analytic ordering links level of data [Strauss and Corbin 1998]), but "no methods, either qualitative nor quantitative, have been developed to explore theoretical connections between concepts that enable practice researchers to construct theory" (Morse and Penrod 1999, p. 146). This indicates the stage of theory development in nursing and the challenge that faces nursing to develop adequate clinically based theory.

The difficulties of clearly delineating the attributes of control from other key concepts such as attachment and information processing which formed key attributes of the concept of control is illustrated in this section highlight the development of a framework of knowledge as a stage in the process of developing clinically based theory. This section describes the evolution of this framework combining concept analysis with critical incidents and actual practice situations to derive a framework that formed the basis of the propositions used as the starting point for the further development of theory relating in the PhD thesis.

Key concepts of attachment, the use of a pause to engage feed-back, information processing and emotional regulation were identified in the concept analysis which were reinforced in the critical incidents and analysis of actual practice situations as central to the development of an adequate nursing theory of control. Additionally the concepts of ambivalence, of reciprocal emotional arousal, peer relationships and help seeking activity were identified from the critical incidents and analysis of actual

practice situations as an important component of a theory of control in nursing practice that involved the 24 hour care of children with challenging behaviours. The evolution of these concepts in the MSc thesis is described below.

Attachment

Attachment was identified in the concept analysis as an *antecedent* to gaining control. Analysis of critical incidents and actual practice situations identified the nurses' intuitive use of micro skills associated with the process of attachment described in contemporary academic literature (Sroufe 1996; Stern 1971,1985). It was clear from the interviews and discussion with the nurses that the nurses were, however, unaware of this literature and of the fact that they were applying this literature in practice. Instead it appeared they had acquired these skills through experiential learning.

Incident to illustrate this.

A nurse (N) gave an example of a young person (P) of 13, who had been admitted to the in-patient unit with multiple mental and social vulnerabilities, which included profound difficulties in tolerating any level of frustration, when P would hit out at both staff and other children. One evening, P was extremely disappointed, because her parents had not rung her. In an attempt to distract P away from her disappointment, N took the girl for a cooking session. N admitted to feeling anxious because the girl was so volatile. However, N was a very experienced and sensitive nurse. The session had actually gone so well, that N felt that the success of the session represented a break through and the girl subsequently began to seek her out spontaneously when she was feeling troubled, whereas prior to this, she had great difficulty in seeking help from any adult. The nurse realised that this was the

beginning of the trusting relationship she was trying to achieve as part of her therapeutic support for this girl. However, she could not initially identify what it was within the session that had made such a difference.

However when the attachment literature was shared with N, she said it was as if a penny had dropped and she was able to identify how she had tuned into P's feelings to establish some interpersonal synchrony and to use this to build on P's confidence and autonomy, whilst acutely recognising when P needed to be rescued because she could not contain her feelings. N was able to use the attachment literature to articulate how she had used her skills to tune into the girl's emotions. At the beginning of the session, P was silent and was gazing out of the window and looking at a tree. N followed her gaze to the tree. N stood in silence next to P until she sensed that P was ready to engage in verbal interaction and then commented on how the wind was blowing through the tree. She felt as if P began to calm down and relax at this point.

Sensing that the girl had lost interest in the tree and was focusing on the chocolate they were going to cook with, the nurse immediately transferred her gaze to the chocolate. The nurse described how she had intuitively concentrated very hard to tune into whatever the girl's attention was on. On reflection she felt that it was a very primitive interaction - just like a mother with an infant. Even the language was quite primitive. They had laughed together when tasting the melted chocolate and simultaneously making 'ooh' sounds of pleasure. The nurse reflected how she had also intuitively focused extremely hard on waiting until the girl needed her help with the cooking tasks so that she could time her support to be in line with the girl's needs. Thus, she tried to help the girl to achieve the cooking task on her own, but was alert to the girl's signs that the task was too frustrating and gave appropriate support.

The nurse had taken for granted the high level of skills she had acquired of being able to tune into highly challenging children. However, following discussion in the group, she felt that she could now articulate these skills to others.

The nurses had acquired these skills experientially, and were therefore, unable to demonstrate any conscious awareness of applying the attachment literature base to their practice and so were initially unable to disseminate their knowledge and skills in the dominant language of psychology and psychiatry. As a result of being involved in the research, the nurses were introduced to the literature on attachment and in particular the papers which described the micro-skills they used in their everyday practice. The literature helped them to interrogate their practice, to articulate their previously tacit knowledge and skills and to systematically analyse and refine their care. Becoming participant researchers also helped the nurses to disseminate their skills and to advocate for the child in a more authoritative way to others by critically incorporating the language of the dominant discourse whilst confidently articulating the adaptation of this discourse in their expert practice.

Nurses were able to refine and develop the body of CAMH knowledge, derived from research literature, because of their considerable experience and expertise in 24 hour care. This equipped them with a sophisticated but initially intuitive awareness of the micro skills and knowledge underpinning everyday interactions with children who had behaviour problems in which they strove to develop the secure sense of trust that is fundamental to any attachment relationship. Access to the body of published literature, enabled the nurses to translate their nursing practices into recognisable scientific language. As a result they were able to refine CAMH knowledge by using

their highly attuned understanding of the 24 hour context with its complex set of interacting variables in order to locate and contextualise the published CAMH literature and its parameters in 24 hour care contexts. For a more detailed exposition of the findings, please see Croom et al 2000 (Appendix 3).

An outcome of the nursing research was the development of a nursing practice framework (see appendix 2) which the nurses felt helped them to work with the child more effectively by systematically analysing the child's needs and evaluating their progress. It was acknowledged that this nursing framework was not definitive, but provided a platform from which to generate future research, development and refinement of nursing CAMH knowledge and skills.

Implications of the nursing research for this thesis: Derivation of Overarching propositions to be tested out with parents in this thesis

The findings of the nursing project (Croom 1996) illustrated that by “analysing a diverse range of specialist literature and experiential knowledge in the context of practice situations” (Croom et al 2000), it was possible to abstract a range of specialist nursing knowledge about how nurses help children with behaviour problems in the 24 hour life space to develop an age appropriate sense of control. From the perspective of the continuing care of the child, however, a key concern arising from this research was the knowledge and skills developed by and available to the parents and other community carers to whom these children are discharged.

Although it is acknowledged that discharge from in-patient unit to the community setting is a crucial aspect of collaborative CAMH care (Audit commission 1999) little research has explored to what extent skills and knowledge can be transferred from a specialist residential CAMH setting to a community setting such as the parental context of care.

This highlighted a research opportunity to work with parents in order to collaboratively explore with them:

- To what extent the nursing knowledge and skills (derived from both empirical and experiential sources in the participative action research with the nurses) were useful and relevant to parents of children with behaviour problems, in the context of their 24 hour everyday care in their community context.
- What other knowledge and skills could be learned from parents that could continue to contribute to a cumulative knowledge base on the 24 hour management of children with behavioural problems
- The potential impact on the capacity of CAMH systems to respond to children with challenging behaviours if their parents become participants in creating and developing knowledge and skills rather than just being recipients of professional knowledge and skills.

Four overarching propositions were thus derived from the nursing research that could be tested out with parents in this thesis with the aim of giving parents a voice and supporting them to care for their children with challenging behaviours. These are:

Box 4: Overarching propositions derived from nursing research (Croom 1996), Croom et al 2000)

- (1) That the nursing knowledge and skills derived from the nursing project (Croom 1996) will be useful to parents in their 24 hour context in the community, when caring for their child with behavioural problems.**
- (2) That the parents can refine and develop the nursing knowledge and skills (Croom 1996) and so add to a cumulative body of practice knowledge and skills related to the 24-hour management of children with behavioural problems.**
- (3) That the parents can increase their capacity to respond effectively to their children with behaviour problems by gaining access to a diverse body of knowledge and by being participant researchers in the knowledge production process.**
- (4) That the service planners and providers can utilise parental knowledge, expertise and insight into caring for children with behavioural problems throughout their 24 hour life span in order to increase the systemic capacity to respond more appropriately and effectively to the needs of these children**

Derivation of sub propositions required to systematically test out proposition 1 above.

In order to test the proposition 1 in box 4, it was necessary to clearly explicate the nursing knowledge and skills underpinning it. This gave rise to a set of sub

propositions. This section will discuss the nursing knowledge and skills which the nurses found were useful and will identify how the sub propositions were derived, which were then tested out with parents in this thesis. The main propositions one to four, given above, can be interpreted as the theoretical propositions to be tested in the research, while the propositions 1.1-1.7 in Box 5 p. 233 can be interpreted as the action or behavioural attributes derived from an analysis of the antecedents, consequences and empirical referents of the concept analysis of control combined with the reflective analysis of the nursing critical practice incidents.

As discussed above, a range of attributes were identified through the concept analysis on control. The following discussion identifies the concept attributes, the literature underpinning them, how the nurses found these useful and the sub propositions, which were derived in order to test out the overarching proposition that nursing knowledge and skills would be useful to parents in the community.

Attachment theory: Its role and contribution to nursing care

Attachment emerged from the nursing and psychology literature as a key attribute in the development of control. Weber et al (1992) found a significantly impoverished attachment history in adolescents with conduct disorders. Wenar (1982) described how the attachment process enables parents to bestow love for conformity to their directives and that the child's concern about being love worthy is a major motivation in complying with socialising directives. Brazelton and Cramer (1990) and Schaffer (1977) used videoed observations of mothers and children in order to micro analyse their interactions. They illustrated the enormous speed with which a human being takes in observations and synthesises it almost immediately in order to engage

meaningfully in reciprocal social interactions. Schaffer (1977, p. 86) described that “the most critical factor was the mother’s sensitivity to the child’s capacity for attention. ... the mother provides a predictable framework of expectation which enables the child to control random movements and attend for longer and longer periods.”

This literature was shared with the nurses, who then analysed it in the context of practice situations for its perceived relevance to their practice. Nurses had long held onto and frequently discussed the belief that the key element to responding to children with behaviour problems was building a relationship with the child. By applying literature on the micro processes involved in early infant interaction and the reciprocal dialogue which evolves (Stern 1985, Schaffer 1977, Sroufe 1996) to critical incidents arising from their daily practice, the nurses were able to develop an insight into and articulate the complexity of the skills they used when developing a relationship with a child, who manifested profoundly challenging behaviours. This enabled the nurses to legitimise their intuitive knowledge that it is crucial to be consistently emotionally available to children with behaviour problems in order to promote a sense of trust with the child, to sensitively interpret the child’s cues for help, to contain the child’s anxiety and frustrations and to predict when the child is able to autonomously respond to limits and frustrations.

Nurses recognised that they centred their care around the development of their relationship with the child and endeavoured to use all interactions with the children as a platform to provide a good experience or a positive learning experience for the child. As one nurse said *“you’re always trying to achieve a therapeutic outcome”*

(Croom 1996). Although all of the nurses emphasised the critical importance of the relationships with the children, from the beginning of the research none of the nurses initially made a direct link between their practice and the literature on attachment. However, they felt that accessing the literature on attachment, as part of the participant action research project, made a difference to the way that they understood, interpreted and cared for the children within their care.

This is illustrated in the following analysis of an actual practice situation described by one of the participating nurses (M): (M) *described how accessing attachment literature* had helped him to articulate the progress of a boy (K) aged 7, who had behaviour problems. M felt their relationship had developed to a point where K had changed from being very distrustful to being able to actively seek out M out for help and support. M described how he had worked hard to get in tune with K by being very sensitive to his reactions so they had learned to “*adapt* to each other better” and were “*more mutually in tune*” (Croom 1996). On reflection M felt that the micro-processes involved in the attachment process (Schaffer 1977, Stern 1985, Brazelton and Cramer 1990) helped him to be aware of the micro changes that were actually occurring in the practice situation, which he had not identified prior to the research. This enabled M to provide a more sensitive and systematic nursing assessment of K’s therapeutic progress. Schaffer (1977, pp. 62- 69) described how the mother continually monitors the baby’s activities, so that her own interventions are in precise synchrony with that of her baby. Schaffer (1977) also described the mother’s exquisite sense of timing and ability to remain attuned to her child. M described how he intuitively applied this through:

“spending time with the child”, “understanding him”, knowing when “to give him space” and not being too pushy” at first and then “because of the relationship you’ve got, you feel you can push the child a little bit more and he’ll feel confident about it” (Croom 1996).

Schaffer (1977) describes how the mother must know when to intervene if she wishes to achieve a predictable outcome. M described how he intuitively knew the importance of *“knowing the child sufficiently”* so that he could predict *“when to move in”* and *“when to give space”* (Croom 1996). Schaffer (1977) proposed that *“control is not an arbitrary imposition on the child but... a two way flow of the relationship.... at a pace appropriate to the child’s capacity, using non-verbal gesture if necessary and delivered only when the attention is upon her”*. M recognised that this provided a rationale for his intuitive knowledge and skills such as saying *“Look at me”* in order to get the child’s attention and only proceeding when he had the child’s attention. M also learned to recognise that a break may be necessary to give K some space or the time to process information.

Research, which highlighted that attachment relationships involve a reciprocal process (Schaffer, 1977, Stern 1985, Sroufe 1996) was important in enabling the nurses to understand the two way nature of their relationships with the children in which they mutually influenced each others feelings and behaviours. In attempting to manage difficult behaviour therapeutically, nurses recognised that both the nurse and the child are subjected to reciprocal emotional arousal. As the carer, the nurse had to manage this emotional arousal in order to be able to contain the child’s anxieties and arousal and so resolve the ongoing situation.

Although Schaffer (1977 p.8) places a major emphasis on early experience as a determinant of later behaviour and refers to this as “almost common sense”, the findings from the nursing study (Croom 1996) illustrated that provided the nurses could give the children alternative nurturing opportunities in which to develop a trusting attachment relationship, the children could use this relationship as a platform to help them develop control and strategies to cope with everyday limits and frustrations. This finding was backed up by Clarke and Clarke (2000) who identify the capacity for children to overcome their early adverse experiences, if they are provided with significantly better compensatory circumstances. Clarke and Clarke (2000) conducted a range of research projects with deprived children in this country and in Eastern Europe and concluded:

“Summarising the main arguments, we indicated that there is no known adversity from which at least some children had not recovered if moved to something better and that the whole of the life path is important, not just the early years” (Clarke and Clarke 2000, p.19).

The literature on the emotional plasticity and resilience which children can demonstrate even in adverse circumstances (Clarke and Clarke 2000) reinforces earlier work by Rae Grant et al(1989). This literature on resilience and emotional plasticity became a major motivating factor for the nurses in the Croom 1996 study as it indicated that their interventions could help these children progress towards health. This finding highlights the potential for exploring this literature with parents, who may have had earlier difficulties with these children, in order to see if it can also be a motivating factor with them.

The findings on the application of attachment literature as a way of understanding and expressing intuitive aspects of nursing practice raised practice questions about the transferability of this method to parents who may similarly benefit from applying this literature to the care of their children. This thesis provides an opportunity to discover how useful attachment literature is to parents and to explore the influence of social and macro factors in the parents' context on the transferability of this knowledge and their capacity to be emotionally available to their children under stressful conditions. This provides the foundation for the first overarching proposition that nursing knowledge identified in the nursing study, could be useful to parents in the community. The findings from the nursing research on attachment led to the formulation of 2 sub propositions to proposition 1 that could be tested out with parents:

1.1. That developing a reciprocal attachment relationship, in which the child and their significant carer(s) become "in tune" with each other is essential to the management of children with emotional and behavioural problems

1.2. In order for carers to manage situations where their child is emotionally aroused/becoming out of control, the carers first need to manage the reciprocal arousal they feel themselves

The contribution of theories of ambivalence to CAMH nursing.

In the previous section on attachment theory, the nurses described how the children could engender powerful emotions in them through the process of reciprocal

emotional arousal. When asked about this, nurses indicated that this was because they had previously felt guilty as nurses/carers for “not liking every child equally” and that they felt particularly guilty if they experienced negative feelings towards a child.

The literature was explored to see if it could help nurses further negotiate the route through the moral complexity of this aspect of their practice. The nurses found the literature on maternal ambivalence (Christine and Correia 1987) helped them to both understand and manage the strong feelings, which can be aroused by children with challenging behaviours. Christine and Correia (1987) explored maternal ambivalence with a group of mothers and found “that every time the mothers in the group came into contact with guilt over ambivalent feelings towards their children.... they began to demonstrate at least transiently an initiative and resourcefulness towards their child”. Christine and Correia (1987) suggest that the conflict which parents experience over the feelings of love and hate at times towards their babies was a healthy mechanism. They described how in their study, parents who experienced any negative feelings towards their babies always reacted by attempting to engage in positive interaction with them and this spurred parents to struggle and understand their baby better. By accessing the literature such as that of Christine and Correia, nurses felt that they acquired a better understanding and insight into their own ambivalent feelings to the children and were then able to recognise how acknowledging any feelings of frustration or irritation about a child to another professional actually galvanised them into engaging in some positive interaction with the child (Croom 1996). This finding highlighted the potential need to explore the literature on experiences of ambivalent feelings with parents. Sub propositions that were formulated from this finding from the nursing research for this thesis were:

1.3. There is a need to recognise that carers have feelings of ambivalence towards those they care for

1.4. Acknowledging and managing ambivalence is a healthy component of close relationships

Information Processing: Its role and contribution to CAMH nursing

Information processing was identified as a key attribute in the literature search undertaken as part of the concept analysis on control. The nurses demonstrated an intuitive understanding that children with challenging behaviours had difficulties making sense of events, especially when they were upset and aroused, but no nurse referred to the literature on information processing. Nurses in the Croom 1996 study found that accessing literature on information processing (Crick and Dodge 1994; Dodge and Price 1994; Dodge and Schwarz 1994) was useful in helping them to unpack and deconstruct the micro processes underpinning the difficulties experienced by children with challenging behaviours. The nurses thus felt that as a result of this literature they developed a greater insight into how to systematically support children with behaviour problems to process information and respond to social cues in ways which helped them to meet their personal, social and developmental goals.

The work of Crick and Dodge (1994) was found to be particularly helpful. Crick and Dodge (1994) proposed an information processing model in which children make sense of and respond to their world through a dynamic series of information processing stages. This involves a continuous process in which a child has to perceive

a situation, selectively attend to crucial aspects of it, decide on the goals, compare this to how similar situations have been handled, decide on a course of action and then learn from it. Crick and Dodge (1994) used this model to help explain how a child's behavioural response to a problematic social stimulus is empirically linked to their characteristic information processing styles e.g. aggressive children consistently show that they selectively attend to cues, which they interpret as hostile, even in apparently neutral circumstances. This provokes them to formulate the goal of seeking retribution and to choose a habitually aggressive response. This tends to elicit a negative reaction from others, which reinforces their learning that others are hostile towards them and stimulates them to maintain their characteristic hostile responses.

Nurses felt that accessing information processing literature helped them to develop their insight into how children with behaviour problems make sense of their world. This insight helped them to systematically support children with behavioural problems by analysing the child's behaviours in micro segments in order to help the child to learn the steps required to perceive information more accurately, interpret situations more effectively and to develop prosocial goals, which many children without problems learn to do without prompting. Information processing helped the nurses to integrate their practice knowledge and experiences, which involved maximising the whole of the child's life space i.e. using their total 24 hour experiences as a series of potential learning and support opportunities. The information processing model of Crick and Dodge helped the nurses to articulate their tacit knowledge that children with challenging behaviours often had a sustained distorted view of reality in which they felt everybody was against them. They built on this to explicate how they intuitively used the opportunities across 24 hour care to

support the children to acknowledge and then challenge their hostile attributions of social interactions and to explore alternative interpretations, which could then support them to formulate more prosocial goals in social interactions.

Another perspective on control, which helped the nurses to develop an insight into how a child with challenging behaviour processes information was that of systems theory, as developed in cybernetics. When this seemingly remote literature was shared with the nurses, they found that a basic understanding of how control is maintained in systems theory, described in engineering and physical theories, helped them to gain insight into the needs of these children and further articulate their intuitive practice. In systems theory, control is modelled as a flow of information through the systems with a feedback loop to detect error. Pauses and checks are included in the system to inform the feedback loop and to indicate whether adjustments are needed and if so, in which direction. This process is described in both control engineering (Dorf 1967) and cybernetic theory (George 1967). Gaining a basic understanding of these models helped the nurses to appreciate that children needed to be able to “pause” or stop in order to gauge their level of emotional arousal and take preventative action before it overwhelms them (Croom 1996). Nurses felt that they intuitively knew they had to support children to stop and think, but had not articulated this or integrated this tacit knowledge into systematic care plans, which could be shared with other professionals and carers. This insight helped nurses to develop care plans which used a variety of innovative ways of supporting children with behaviour problems to pause/stop long enough to process information and thus to think about the potential consequences of their actions. These included visual cues, verbal prompts and stories.

The findings from the research on information processing and systems theory in relation to information processing, led to the formulation of further sub propositions.

1.5. Understanding how to help a child to “process information” in a way which enables him/her meet his/her social, developmental and emotional goals is essential. Articulating the knowledge and skills on the various micro stages in information processing are useful to carers in systematically supporting children with challenging behaviours. These micro processes include:

- *Helping a child to “create a pause” in order to “stop and think” about the situation they were involved in*
- *Helping a child to selectively attend to social, emotional and situational cues in a range of situations*
- *Helping a child to consider a range of interpretations of these cues*
- *Helping a child to manage the emotional arousal which can arise from these interpretations*
- *Helping the child to be able to formulate the goal/ outcome, which they wish to achieve from a given situation, recall how they have previously coped in that kind of situation, think of alternative ways of coping and select a strategy which can help them achieve their chosen goal*
- *Helping a child to feel confident about being able to implement the chosen strategies to achieve their goal*
- *Helping a child to evaluate their performance and so learn from one situation to another.*

The contribution of experiential nursing knowledge and skills to formalised CAMH nursing knowledge.

In addition to the literature identified in the concept analysis, nurses in the Croom 1996 study also identified skills and knowledge derived from their own practice experiences, which they recognised were useful when working with children with behaviour problems to effectively process information. Nurses possessed a tacit recognition of how difficult it can be for children with behaviour problems to proactively seek help. Through discussion and reflection on critical incidents, the nurses identified how a feature of the relationship they built with a child was their ability to intuitively tune into the child's non verbal signals that they needed help e.g. a child may stand close to a nurse in order to indicate a need for help but offer no other verbal or physical gesture. On further reflection, the nurses recognised that as the child learned to trust that the nurse would be emotionally and physically there for them if they sought help, the child was more able to move onto verbal requests. The nurses recognised their skills of systematically observing the child's progress from non verbal to verbal signals for help represented significant therapeutic progress, which they had not previously articulated. They also found that describing this in multi-disciplinary groups, enabled them to become better advocates for the child and to optimise the data arising from their 24 hour observations. This formed the basis for the next sub hypothesis to be tested out with parents in this thesis:

1.6. That it is essential to understand and acknowledge that children who exhibit behavioural problems often have difficulties in expressing and also in appropriately seeking help when they are frustrated or distressed.

Peer Relationships

Reflection on and analysis of the nurses practice experiences highlighted the importance of peer relationships. Nurses identified that to promote peer relationship skills, they had to integrate a sophisticated understanding of how much the child was able to engage in a reciprocal trusting relationship, how much they were able to take on board information in order to negotiate or compromise, especially when emotionally aroused and how competent they were in social interactions and with social skills. Nurses identified that this required high levels of supervision of the young people and their peer interactions in order to make judgements on when adult intervention was necessary and when the young people could be supported to use their own social skills with minimum prompting. A further hypothesis was therefore derived:

1.7. Knowledge and skills on peer relationships which nurses found useful in an in-patient setting such as high levels of supervision and teaching social skills will be useful for parents managing their children in their family setting within the community.

The sub propositions are compiled below into box 5:

Box 5: Sub propositions (derived from the research with the nurses), which were inductively analysed with the parents to test out proposition 1 in box 3.	
1.1	Developing a reciprocal attachment relationship, in which the child and their significant carer(s) become “in tune” with each other is essential to the management of children with emotional and behavioural problems
1.2	In order for carers to manage situations where their child is emotionally aroused/becoming out of control, the carers first need to manage the reciprocal arousal they feel themselves
1.3	There is a need to recognise that carers have feelings of ambivalence towards those they care for
1.4	Acknowledging and managing ambivalence is a healthy component of close relationships
1.5	It is essential to understand and acknowledge that children who exhibit behavioural problems often have difficulties in expressing and also in appropriately seeking help when they are frustrated or distressed.
1.6	<p>Understanding how to help a child to “process information” in a way which enables he /she meet his/her social, developmental and emotional goals is essential. Knowledge and skills on various stages in information processing are useful to carers in managing children. These include:</p> <ul style="list-style-type: none"> • Helping a child to “create a pause” in order to “stop and think” • Helping a child to selectively attend to social, emotional and situational cues in a range of situations • Helping a child to interpret these cues in ways, which are effective to them in meeting their social, emotional and developmental goals. • Helping a child manage the emotional arousal which may arise from the interpretation • Helping the child to be able to formulate the goal/ outcome, which they wish to achieve from a given situation, recall how they have previously coped in that kind of situation, think of alternative ways of coping and select a strategy which can help them achieve their chosen goal • Helping a child to feel confident about being able to implement the chosen strategies to achieve their goal • Helping a child to evaluate their performance and so learn from one situation to another.
1.7	Knowledge and skills on peer relationships which nurses found useful in an in-patient setting such as high levels of supervision and teaching social skills will be useful for parents managing their children in their family setting within the community.

Implications of the nursing research for the methodology to be applied in this thesis

One of the central findings from the nursing study was that although the nurses were intuitively incorporating the principles of the attributes of control found in the literature in their practice, they did not articulate their skills in the language of the dominant scientific literature. Nevertheless, once they made the link back to the literature they were able to use it in practice situations to articulate their previously tacit experiential knowledge base. This helped them to not only develop a more systematic approach to care, but it also gave them more confidence in disseminating their theory/model of care in a multi-disciplinary team. The findings indicated that prior to engaging in the research, the nurses were not only potentially excluded from access to an ascribed position of power within the team through their lack of visible use of the dominant language of empirical research but also from being able to develop their own body of practice knowledge, which is relevant in their context. As a practitioner researcher, identifying the tacit oppression which becomes embedded in practice culture, and how to challenge this oppression through a pragmatic response in the form of the nursing practice framework (appendix 1) was a fundamental finding and highlighted the importance of adopting a methodology which overtly addressed oppression in the PhD thesis.

Although the nursing research (Croom 1996) was carried out with nurses in an institutional setting as opposed to a community setting, there are some similarities between the nursing research and this thesis, which permit some transferability of the methodology from the nursing study to this thesis study with parents. These include:

- (1) The application of an inductive analysis to a “deductive framework”, as discussed by Procter (1995, p.66) and Morse (1995). In the nursing research (Croom 1996) the concept analysis of the literature provided the critical edge (heuristic device) to help the nurses to articulate practice knowledge. In the PhD the nursing framework derived from the nursing study (Croom 1996 - appendix 2) and in particular the overarching propositions and sub-propositions were used as the deductive framework. This provided a heuristic device to help articulate the tacit, taken for granted knowledge and skills of the parents and simultaneously tested out the generalisable parameters of the nursing framework using the experiences of the parents in their own context.
- (2) The application of critical incident technique. Critical incident technique (Wilson and Fish 1993) was used with nurses. In this thesis, critical incident technique was used with parents to access their everyday life experiences and thus generate authentic data from which to inductively analyse the nursing knowledge and skills and also to critically interrogate the parents practice to identify any tacit knowledge, skills and expertise, which they used to effectively care for their children.
- (3) The action science principles (Friedman 2001) used in the nursing research to deal with situations of uniqueness, which are not compatible with an experimental quantitative approach, were also applied in the PhD along with the action research (Schon 1987) principles of iteratively testing out solutions to practice problems.

Through the nursing research process in which the nurses actively critiqued the literature for its relevance to practice and then built on this to change and develop practice, the nurses became engaged in practitioner research which was both emancipatory research and which also aimed to improve practice. The operationalisation of these values were crucial in the nursing research and as a practitioner researcher, I felt that these would also have to be central to research with parents. This meant that I had to address the additional complexity of not only doing research with fellow nurse practitioners, but also with clients, whom I was attempting to engage as research partners, whilst also offering them a service. I recognised the potential power differential between nurses and parents as carers of children referred as clients. Thus the methodology for the PhD incorporates the above methods used in the nursing research (Croom 1996) along with critical social theory in order to address the additional macro/socio-political factors, which come into play in the shift from an institutional to a community context and to address the potential power issues arising from my simultaneous role as a professional and as a researcher. The addition of critical social theory was proposed as a method for analysing the dynamic between patient and carer knowledge and professional knowledge. This will be discussed in depth in the course of the thesis.

This chapter provides an overview of the background research on which the thesis built. Although the findings for the MSc clearly do not form part of the PhD, the chapter has described the theoretical and analytical process used to build on these findings as a basis for the PhD. The method of concept analysis proposed by Walker and Avant (1988) and used in the MSc was not sufficient on its own to develop

practice knowledge as this chapter demonstrates. It did, however, provide a systematic and transparent method for accessing and analysing a range of literature which underpinned a key nursing concept - control. The development of practice knowledge required the collection and qualitative analysis of practice data and it was only by combining the two that it was possible to start developing a framework of practice knowledge as set out in the nursing practice framework (Appendix 1). The transfer of this knowledge from practice to the community situation of parents required this knowledge to be formulated in such a way that it could be inductively tested as described by Morse and Duberneck (1995). This gave rise to the over-arching propositions (box 4) and the sub-propositions (box 4) that link these propositions back to their data sources and so maintain the conceptual integrity and clarity of the analysis.

In undertaking this concept analysis other key concepts such as attachment, information processing and ambivalence were identified. Morse and Penrod (1999) have described the paucity of methods to guide researchers in linking related concepts to develop clinically based theory. The research presented in this thesis is hampered by this lack of method. Without a well-developed methodology with which to develop clinically based theory the thesis has to rely on an integration of a range of methods none of which were designed for the purpose in which they are being used. The thesis endeavours to overcome the obvious limitations this imposes on it by using a rigorous method of analysis which makes transparent the transformation of concepts at each stage of the data collection and analysis process.

Chapter Six

Findings Chapter

This chapter presents the findings from the collaborative research with the 25 actively participating parents in which they engaged in an inductive analysis of the overarching propositions, given in Box 4, which were discussed in chapter 5. The relevance of the propositions to the parents, their limitations and parameters of transferability will be systematically documented from the 90 reflective action cycles which were collected across the 8 cohorts, as discussed in Chapter 4. The findings chapter is divided into three sections.

Section One

Section One presents the findings from the inductive analysis with the parents of proposition one and proposition two given in Box 4 in chapter 5, page 219.

The propositions given in Box 1 are over-arching theoretical propositions. These are broken down into behavioural or action propositions which are presented in Box 5.

The derivation of these propositions was given in the previous Chapter, 5.

The development of action or behavioural propositions given in Box 5 (depicted in chapter 5 page 233) represent the application of knowledge and skills in practice and therefore, enabled the testing of the more abstract propositions in Box 4 through a detailed analysis of critical incidents and action learning cycles described by the parents attending the group sessions. Section one presents an analysis of the sub-propositions given in Box 5. It describes how the parents explored these propositions for their relevance and application to their everyday lives.

This involved the parents analysing whether the propositions were useful (or not useful) to them in their everyday context when caring for their children with behaviour problems and the situations and contexts in which they were and were not

able to use the knowledge and skills underpinning the propositions given in Box 5. Section one also includes an analysis of proposition 2 (Box 4) and therefore includes the refinements, which the parents brought to the nursing skills and knowledge (Croom 1996 and Croom et al 2000). These refinements emerged from an exploration of the everyday lived experience of the parents as well as their inductive analysis of academic and professional literature shared with them during the course of the parenting groups.

The literature selected for dissemination and critical analysis to the groups related to the experiences, incidents and problems, which the parents brought to the group. The contexts in which the parents found the nursing knowledge and skills (Croom 1996) and further analysis of literature to be useful, will be described and circumscribed.

The critical and theoretical issues arising from the selection of literature for use with the parents will be discussed in more detail in discussion chapters seven and eight.

Section Two

Section two presents the findings from the inductive analysis with the parents of proposition three (Box 4) in which access to the nursing knowledge and skills (Croom 1996, Croom et al 2000) and participation in the research process was analysed in the practice context to see if it affected the parents capacity to respond to their child with behaviour problems in a way which increased the well-being of the child, parent, family and wider community of carers such as teachers.

Section Three

Section Three presents the findings from the inductive analysis of proposition four (Box 4). This involved an exploration of how parents could contribute to the

professional and systemic capacity to respond effectively to the needs of these children if professionals were provided with increased insights and skills derived from the family's 24-hour experiences/expertise in caring for children with behaviour problems. Analysis of proposition four (Box 3) also enabled identification of the factors which could constrain parental capacity to respond to the needs of these children.

Data Sampling Strategy

In keeping with the collaborative participative approach, the authentic voice of the 25 parents who actively engaged in the research will be used to illustrate the parents' inductive analysis of the propositions and sub-propositions listed in Box 3 and 4. The analysis identifies when the propositions derived from the nursing research were supported, falsified or refined by the parent's experience of caring for these children. In order to provide representative reporting, care has been taken to select quotations from the total set of transcripts derived from the 25 parents who actively participated in groups across the eight cohorts, i.e. who attended at least 75% of the sessions and who completed at least one action research cycle, which formed the basis for the data used in the analysis (see chapter 4).

This proved not only to be the most representative but also the most pragmatic way forward as the parents who dropped out, tended to do so after their attendance at the first session and did not actually contribute very much to the session which they attended. By not returning to the group, they were unable to contribute to the action learning cycles. It appeared that subsequent attendance seemed to be co-related to engagement in the first session of each cohort. The number of affirmative or contrary cases will thus be derived from data provided by the contribution made to the groups

from the total sample of parents who attended at least 75% of the group sessions over the eight cohorts (n=25 parents). All of these 25 parents attended both the first and the last session. Three parents in cohorts 1,2,3,5,6,7,8 and four parents in cohort 4 all met the inclusion criteria. Examples of critical incidents from the group will also be incorporated to illustrate how the propositions were supported or circumscribed by using authentic examples of parenting practice. The opportunities and disadvantages of the approach are discussed further in Chapters 8 and 9.

As discussed in Chapters Three and Four, the complex nature of carrying out research whilst engaged in practice meant that the therapeutic needs of the parents always took precedence over the research objectives. Thus the application of critical incidents technique i.e. reflection on action was applied to incidents that were often discussed over a period of weeks. The critical incidents reported are therefore provided because they led to reflective action cycles which had a clear beginning, middle and end within one cohort and are therefore easily reported but more importantly, because they are clearly representative and integrate all of the issues, which emerged across the cohorts and also because they constitute incidents which formed the focus for reflective group discussions on an ongoing or intermittent basis. For instance, parents might return to earlier incidents during a later discussion and re-analyse these incidents in the light of recent discussion or learning.

Each proposition is analysed separately and starts with a presentation of data which supports the proposition. This is followed by a presentation of data which highlights the limitations of the transferability of the proposition derived from the nursing context to the parental context. Where this is found, the analysis of each proposition concludes with presentation data derived from the parental experience which adds further knowledge or refines the initial proposition.

Section One: Findings from the inductive analysis of propositions 1 and 2.

In section one, findings from an inductive analysis with the parents of each of the sub propositions given in Box 4 will be presented. The analysis of the sub-propositions given in Box 5 will be used to test the relevance and transferability of propositions 1 and 2 in Box 4.

Inductive analysis with the parents of Sub-Proposition 1.1:

That developing a reciprocal attachment relationship, in which the significant carer becomes “in tune” with the child's needs is essential to the management of children with emotional and behavioural problems

Evidence which is supportive of proposition 1.1

Like the nurses in the previous study (Chapter 5) all of the parents intuitively highlighted the crucial importance of their relationship with their child in managing their children and described how:

“I just want to love him in the best way I can” (Parent 1 cohort 1)

“It's natural, isn't it - a mam loves her bairns” (Parent 3 cohort 2)

“Your love your bairns - it's only human” (Parent 2 cohort 7)

The parents' experiences were also similar to the nurses' experiences discussed in Chapter Five, as none of the parents consciously used or were able to discuss any of the plethora of literature on attachment. Attachment and the development of relationships with a child was seen as a natural and spontaneous process i.e. like the nurses, parents saw the development of close relationships as an instinctive response. This meant that any perceived “failure” to achieve a close, reciprocal attachment was a reflection on their caring/parenting ability and commitment and represented a major source of guilt for them.

Parents identified how this was made worse by their perceived social idealisation of the carers/parenting role:

"You see in all the magazines ... being a mam is meant to be the dream come true."

(Parent 3 cohort 4)

All of the 25 parents across the eight cohorts admitted that they felt under pressure from the media and other sources to live up to this idealised maternal role. They also identified the consequences of this socially constructed ideal on their lives:

"It's like you should be always giving.... you're not meant to have a life when you

have a bairn" (Parent 2 cohort 6)

and the social penalties and blame they felt they experienced for any deviance from being completely immersed in and satisfied by this caring role:

"It's always the parents fault - doesn't matter where you go" (Parent 3 Cohort 5)

The parents' sense of guilt and shame because they felt that others perceived that they were failures as parents, was initially expressed by all of the 25 participating parents across the eight cohorts. However, through gaining access to knowledge on the complex process of attachment, these parents were able to appreciate that there were circumstances in which parents and carers needed to have a greater depth of knowledge about how to develop a relationship with their child and to receive extra support to achieve this e.g. when dealing with a child with temperamentally challenging or unpredictable behaviours or when parents themselves were under significant stress. All of the participating parents particularly found it helpful to explore the literature, which depicted attachment between parent and child as a two way process. This helped them to challenge their socialised beliefs that attachment is a one way instinctive response from the mother/caregiver to the child and enabled them to develop insight into how some children are genuinely harder to tune into than others. This had the helpful effect of alleviating their sense of guilt for feeling that they were unable to *"connect"* to their child and simultaneously freed them up to focus on some ways of getting in tune with their child.

The literature which identified the complex micro skills involved in attachment (such as Sroufe 1996; Stern 1971 and 1985; Schaeffer 1977) which the nurses found helpful was also found to be useful by the parents. Parents found that understanding the complexity of the attachment relationship was helpful in understanding how much skill is involved in the attachment relationship. Instead of expecting themselves to spontaneously “know” their child, they allowed themselves to stand back and do a “study” or close observation of their child. They gave themselves explicit permission to take the time to learn about their children, whom they had previously perceived as unpredictable and challenging e.g. parents began to observe patterns across a variety of situations and found appropriate opportunities to let the child take the lead:

“I’m beginning to notice things about him. I always felt that I had to be on his back before because me mam was always saying I was too soft” (Parent 4 cohort 4)

In order to help parents explore the two-way relationship, parents were also offered the opportunity within the groups to role-play both the parent and child for a short period of child centred play. Not all of the parents wished to participate in this and the choice was left to them (13 participated out of the 25). However, all of the parents who did not take part in the role-play said they enjoyed watching and learning from this experience. Six out of the 13 parents who participated in the role-play admitted that they found “playing the parent” difficult and admitted:

“I wasn’t played with meself when I was a bairn- me mam didn’t play with us- she cooked for us”. (Parent 2 cohort 6)

“I played, but I don’t remember playing with me mam”. (Parent 3 cohort 7)

Five of the parents had good experiences of role modelling from their parents, who actively played with them as children and they were able to act as facilitators and role models themselves by sharing the importance of their experiences with the group. In this way, they helped increase the capacity of the whole group to engage in culturally acceptable, child directed play. Across the eight cohorts, all of the 25 parents found it difficult to follow the child’s lead when playing the parenting role. However, they all found that they enjoyed playing the role of the child and this helped them to

experience how good it felt to have someone focusing on them and allowing them to take the initiative in play. This stimulated a discussion on the process of attachment and relationships in which both parties have to tune into each other. This provoked an acknowledgement of the complexity of the attachment relationship and a recognition of how difficult it can be to effectively engage in attachment behaviour, particularly when under stress. Parents also identified how problematic it can be at times to get others (e.g. partners, grandparents, teachers, health visitors) to acknowledge the full range of attachment issues and the skills and effort involved and the support required to achieve a reciprocal attachment.

"I always thought it was me-that there must be something wrong with me - I can connect with me other bairns but not with X. I mean you're not meant to feel like that about your bairnbut now I can see how I have tried to connect with him ... but what works with the others won't work with him... they should bloody well tell you these things when you have a bairn." (Parent 1 cohort 1)

"I kept saying he was different- I knew he needed different things from my others- but no-body seemed to listen- me mam said I was wrong to treat him differently ... in the end I questioned it meself" (Parent 2 cohort 7)

All of the parents across the eight cohorts articulated the importance of feeling that they were **"connected"** (this was the parents' language) to their child. There was also a strong theme in each cohort related to the guilt experienced by parents when they did not feel connected and the emancipation from that guilt as a result of being able to ventilate these feelings and have relevant literature shared with them, which allowed them to explore a range of reasons for the feelings of not being connected.

Limitations to the transferability of proposition 1.1. identified by parents

Parents illustrated that their capacity to apply knowledge on attachment and to develop a reciprocal attachment was not just about the transfer of information on the complex set of micro processes underpinning the 2-way attachment relationship, but was also related to being able to emotionally internalise that information and to access it when they were in situations of extreme distress or physical exhaustion. The

parents identified that achieving this emotional availability required a number of conditions. They felt that they not only needed to access the knowledge on the complexity of attachment, but that they also required have sufficient emotional capacity to “tune into” their child and respond to their actual needs. Their emotional capacity depended on having enough psychosocial support, such as supportive extended family or social networks and recreational opportunities for their children and also being able to feel good about themselves. The parents were thus able to highlight that accessing knowledge and skills was helpful but not sufficient in developing this emotional capacity. Psychosocial support was an essential prerequisite for parents being able to utilise external resources (such as research) and to then be able to harness their inner strengths and competencies.

When discussing the importance of the therapeutic relationship with children, the previous study with residential nurses (see chapter 5) emphasised the importance of the creation and maintenance of a “therapeutic milieu” in supporting the nursing staff to be consistently emotionally available to vulnerable children, who may be emotionally highly defended and hostile. The psychosocial support from the milieu helped the residential CAMH nurses to continue to provide the nurture, anticipation and guidance, which the children needed in order to help them to meet their social, emotional and developmental goals. Unlike the nurses in the previous study, none of the parents across the cohorts in this thesis initially felt they were part of a supportive social system, which resembled a supportive ‘therapeutic milieu’. All of the parents reported feeling that they thought others perceived them as inadequate or “bad” parents. Sixteen out of the 25 parents across the cohorts felt that this had had an impact on how they saw themselves and led to them losing confidence in their parenting ability and their self esteem. Only five of the 25 parents initially thought that they were good parents, but even they reported that they felt that others perceived them to be “bad parents” and four of the parents said that they vacillated between these positions.

As one parent in cohort seven admitted in the evaluation of the final group session:

“When I first came to the group, I thought you would just tell me I was a useless parent - I kept waiting for it”. (Parent 1 cohort 7)

In the final group evaluation of each cohort all of the parents acknowledged that they had needed help to feel “cared for” themselves before they could meaningfully engage in discussions on relationships with their children.

“I know now that I need help... I need to feel supported if I'm going to help me bairn... it's so easy to forget that” (Parent 1, cohort 1)

“I find that coming here helps me to be there for him- before I felt on me own- when you feel people are going to listen and just be there for you each week, it lifts you up ... when you feel better about yourself, you feel better about your bairn” (Parent 3 cohort 3).

In each cohort, parents gradually began to demonstrate that they acknowledged their own right to be nurtured and cared for. They actually began to encourage each other to spontaneously and physically applaud each other when they did something “for themselves” as they recognised that this had a mutual benefit for their children:

“I bought an ice cream. It was just something for me and it felt good. If I feel good, I know I can handle him better”. (Parent 2 cohort 4)

“I usually spend all of my money on them but I bought a pair of socks ...99p... but they were for me and I felt OK about it... and it helped me feel better about them” (Parent 3 cohort 6).

The value, which the parents placed on 'feeling cared for' and giving themselves permission to care for themselves, was a central theme across the cohorts. The parents evaluated that the sense of trust in the group was built up through the process of “being cared for” e.g. they liked being provided with and served drinks and biscuits/cakes. Offering a coat when one mother was cold elicited the response:

“We get well looked after here, don't we?” (Parent 4 cohort 4)

The power of this “care” appeared to be illustrated when one of the facilitators in cohort four acknowledged that a mother looked tired. The mother revealed that she had suffered from toothache all weekend. The facilitator gave the mother some

paracetamol to relieve the pain and the group spent some time sympathising with the mother and encouraging her to go to the dentist. In about ten minutes the mother looked and said she felt much better and began interacting in a positive way. The mother later said:

"I felt crap coming here this morning... I didn't know whether to come, but I know I feel better if I come... even my tooth feels better" (Parent 4 cohort 4)

All of the mothers felt that they had lost all sense of themselves and all but one, who was employed, defined themselves totally in terms of being caregivers to their children. They expressed how valuable and unusual it felt for them to "be listened to" in the groups.

Their sense of trust in the group progressively grew as they discovered that even when they "disclosed" incidents which they perceived demonstrated their failures as mother (and therefore of themselves) that not only were they still valued by group members but they were actually helped to reflect on and recognise their strengths and to acknowledge how caring they actually were e.g. one mother in cohort five described how she had completely lost her temper with her child and had shouted at him and expressed how totally fed up she was with him. She appeared to feel very distressed at her feelings of hostility towards him. The group members empathised with her feelings and her distress. On further exploration, the mother identified that soon after this incident, her little boy had been upset by a peer. He had turned to her for comfort and she had responded with great sensitivity. When the group members put it to her that her true caring as a mother was expressed through this response, both she and the rest of the mothers agreed that although this made sense, they often found it difficult to forgive themselves in these circumstances:

"I feel as though everyone I see is telling me it's my fault- I feel as though it is my fault" (Parent 2 cohort 5)

The parents thus recognised that for parents to nurture and to be able to operationalise information, they need to be nurtured and to feel good about themselves in order to withstand the social pressure and social projection of blame onto parents, which they felt they experienced from a wide range of sources. Their experience indicates that

currently the very parents who needed the individual and psychosocial nurture most were actually being blamed and simultaneously denied the knowledge, which could help them to critique the validity of being perceived as a “bad parent” with the consequent social blame and penalties. However, the parents illustrated that their capacity to respond can be increased by participating in the development of a group milieu in which they feel respected, supported and informed and through which they develop the confidence to critique the system and services. All 25 parents unanimously agreed that they felt that the services they were engaged with were only there for the child. Parents felt that this had to be challenged in order to develop recognition of the need to take care of the caregiver.

Parents across the cohorts appeared to express a significantly greater level of stress than the nurses (Croom 1996) in coping with the rejection expressed by children with behavioural problems and this reduced the total level of emotional availability, which they had for their child. The parents described how they felt that a child acting in an emotionally negative or rejecting way to parents was “not natural”. The level of emotional pain expressed by the parents in the groups was so profound that it appeared to be qualitatively different from the nurses’ feelings of disappointment or professional failure, when they described working through “a stage” when the child was acting in a rejecting and hostile manner towards them. However, parents found that sharing their experiences of pain and distress in the group was very helpful. All of the 25 actively participating parents across the cohorts admitted that they had previously felt that they were the only ones, who had experienced intense expressions of rejection from their child and this had caused them to feel guilty and isolated.

“it breaks my heart ...it's as if he hates me at times... I thought I was the only one who ever felt like this”. (Parent 2 cohort 2)

*“It's so good to know I'm not the only one... I feel I can cope with it better now”
(Parent 4 cohort 4)*

Refinements which parents discussion brought to proposition 1.1.

The parents were able to bring a considerable number of refinements to the nursing knowledge and skills on attachment (Croom 1996). This arose as a result of both an

analysis of their experiences and also through an iterative comparison of their experiences to current literature. Initially in the group, parents tended to understand and interpret their child's behaviour through negative attributions e.g. all of the 25 parents initially expressed negative attributions of their child's behaviour such as:

“they just do it to wind me up.....” (Parent 3 cohort 7)

“they seem to enjoy upsetting every body” (Parent 3 cohort 8)

The range of ways in which parents expressed that their children were challenging and unpredictable initially proved to be difficult to explain or manage by solely applying the nursing knowledge and skills developed from the nursing study (Croom 1996). In an attempt to respond to the parents' feelings and experiences, a further search of the literature was done to explore if any additional knowledge and skills could be found that the parents would find helpful in understanding their child's behaviours. In comparing the parents' experiences to the wider literature, the research on temperament appeared to be potentially useful in developing a greater insight and coping skills (Please see Chapter 2 and Appendices 6 and 7). When the temperament literature was introduced to the parenting groups, all of the parents identified that their children were temperamentally challenging in some or all of the traits identified by Thomas and Chess (1996) and Turecki and Tonner (2000) in terms of negativism, persistence, intensity of emotional reaction, difficulties managing transitions /changes in everyday life routines life, impulsivity. Eighteen out of the 25 parents reported that their children manifested all of the most challenging traits identified in this literature and the other seven reported that they felt their children manifested most of them.

The parents seemed to really value having information on temperament shared with them. On being given a list of the attributes, which described very challenging temperaments, many of them echoed comments such as:

“I can't believe it –this is him... I've never seen all of this written down” (Parent 2 cohort 5)

“It helps to see this - I can explain to me mam that I'm not always giving into him”
(Parent 1 cohort 4)

"I wished I'd been given this years ago". (Parent 3 cohort 2)

All of the 25 parents reported some degree of being "more in tune" or "more connected" to their children as a result of applying information about temperament to their child. Some quotes to illustrate this include:

"I used to think he came from Mars or that they must have given me the wrong baby in the hospital (he doesn't look like me) but now I feel as though I'm beginning to connect with him". (Parent 3 cohort 6)

"I'm better with him now... then he makes me feel good when he responds better ... then I feel better and it feels like something is falling into place" (Parent 1 cohort 2)

"I feel I can predict him more now. When he's likely to go off it, he starts picking his fingers and then he puts his hands to his face and I think -catch it quick before he winds up" (Parent 1 Cohort 8)

Exploring the child's temperament also seemed to help the parents to understand the temperamental mismatch which often occurred between their child and significant caregivers such as grandparents or teachers. They helped to develop a window into their child's perceptions of the world and their experiences and to express a deep sense of empathy for their children:

"It must be awful for him always feeling that he'll get the blame" (Parent 1 cohort 3)

"He must feel that he can never get it right" (Parent 2 cohort 4)

Understanding these emotions helped parents to develop (or reinforce) their own sense of advocacy for their children:

"I'll have to stick up for him. Because nobody else will be bothered to try to understand him" (Parent 1 cohort 5)

The 25 parents unanimously found that accessing the literature on temperament helped them to articulate their tacit knowledge that their child needed to be cared for in a specific way, which responded to their child's temperamental traits. All of the 25 parents across the eight cohorts reported that temperament had not been discussed with them in what for some had been significant contact with a range of professionals in health, education and social services. This appears to represent a missed opportunity as access to and developing an understanding of temperament provided these parents with a useful alternative explanation for their child's behaviour, which they could then share with others and so advocate for their child:

"Me mam just kept saying that he needed a good scelp... the teacher said he misbehaved... deep down, I felt as though it was more than that, but you get worn down... you feel as though they must be right" (Parent 1 cohort 2)

Exploring temperament helped all of the 25 parents to reframe their current attributions of their children as always being deliberately naughty, which had arisen because there was no alternative explanation for their child's challenging behaviours. An example of the kind of attributional transformation, which occurred, was the change from the attribution of the child's behaviour at the beginning of the group from:

"He just deliberately winds me up" ... I can see it in his face"
to *"I know he needs to be helped in a certain way sometimes."* (Parent 2 cohort 5)

The reattribution of behaviour also appeared to help all of the 25 parents to understand and so feel more in control at least some of the time and this helped them to manage their children in a more emotionally neutral way, which the children responded to:

If you're calm with them, they'll be calm with you." (Parent 1 cohort 3)

It also helped the parents to tune into and meet the individual child's needs:

"Most of the time I can understand what he needs better now ...that makes me feel better, so I'm more patient with him." (Parent 2 cohort 2)

Discussions on temperament also helped parents to gain insight into why children seemed to get into difficult situations e.g.

"He wanted to put on his blue shirt and I told him it wasn't dry... he got into a right mood and went on and on about it for 2 hours- by that time the shirt was dry, but I thought – how the bloody hell can you keep that up." (Parent 3 cohort 7)

We were able to discuss across the cohorts how children with a challenging temperament could go on and on, as one of the traits of a challenging temperament was "persistence" i.e. they got locked into a train of thought and could not get out of it on their own, but needed to be "rescued" by significant carers and gradually helped to understand and manage their difficulties. All of the cohorts found the work of Turecki and Tonner (2000) useful in recognising how helpful it can be to a child if the parent articulates and empathises with the difficulties arising from their temperamental profile, by using phrases such as "I know you find new situations difficult". Some quotes from the parents which illustrate how useful they found information on temperament include:

"I think it helps him to feel I understand a bit of what's going on ... I can see that in his face... I don't get so mad and I think that helps too." (Parent 1 cohort 5)

"It's easier now I understand some of his behaviours and I can explain it to me mam or the teacher ... I can say –look, he finds change difficult so just give him a bit of space when he's going from one thing to another-like when he has to come into class and settle down after his break, when he's been running around daft." (Parent 1 cohort 6)

Despite literature on temperament being in the public domain for more than 25 years, it had not been shared with the parents prior to the groups. Parents felt strongly that information on temperament should not only have been made available to them as parents, but also to teachers and grandparents and other significant carers with whom

the child had contact. However, the parents were also able to recognise that information alone was insufficient. They explored how managing temperament successfully depended on a number of psychosocial factors such as how they were feeling and the number of stressors they were under.

“It isn’t just this – [i.e. temperament –my emphasis] it’s everything-all piled up together.” (Parent 1 cohort 8)

“Sometimes it makes sense and I feel great and other times, everything just gets on top of me and all of this goes out of the window.” (Parent 2 cohort 5)

Parents also recognised that whether a child’s temperament is successfully managed depends not only on the parents’ responses but also on how other significant adults react to the children. All of the 25 parents commented on the importance of the class teacher to the child.

“It’s alright me knowing this -I need the teacher to understand.” (Parents 3 Cohort 6)

Only one parent out of the 25 initially thought that the child’s teacher was in tune with the child’s temperamental needs. However, by the end of the groups this rose to six because the parents felt that they had successfully negotiated their children’s needs with the class/head teacher and had managed to stay calm enough to appreciate and acknowledge the difficulty the teacher had in dealing with 30 children plus their child.

The parents felt strongly that the potential to increase the capacity to respond to children with challenging behaviours through applying the knowledge and skills related to temperament is limited by the lack of dissemination of this knowledge to parents as well as other significant carers such as grandparents or teachers.

Critical incident two from Parent 1 in Cohort 3 provides an example of how gaining knowledge of and understanding temperament in relation to her son, 'W', had helped her to be more empathic to her child and to manage him more effectively:

Parent 1 in cohort 3 brought an incident to the group in which she described how she had volunteered to go with 5 year old W on a school trip because the school felt that his behavioural difficulties were beyond what they could cope with on a school outing without extra support. Thus if she had not been able to go, W would have had to stay behind.

Parent 1 therefore accompanied W on the trip. Following lunch, all of the children went to the lavatory. As only female teaching staff were available, they asked all of the children (boys and girls) to go to the ladies lavatory. W had just started going to the boys' lavatory when he was out with his family Prior to gaining her insight into temperament, Parent 1 said that she would have insisted that W follow the same rules as the other children. However, she now recognised that her son had a genuine difficulty with changing routines and also with persistence and could "go on and on" once he got something in his head. He became upset about being asked to go to the girls' lavatory. Parent 1 described how she "felt for him" and discussed how understanding and tuning into W's problems with changing routines enabled her to have the confidence to challenge the rule that he do the same as the others. She reported how she had stayed calm and confidently but quietly said to the teacher that she would take him to the boys' lavatory. She discussed how good she had felt about being able to achieve this and how she felt that her son had appreciated this. She felt that by being able to challenge the rule that all of the children had to do the same thing, she had avoided a tantrum and enabled her son and the class to have a good day. She reflected how all of the other boys were able to go the girl's lavatory without any problem, but she was beginning to recognise when her son had a genuine temperamental difficulty with change in routine, and how this could come across as persistent non-compliance.

This critical incident given by parent 1 in cohort 3 provoked a group discussion where the parents explored how they could recognise when to be empathic with a child, because the child genuinely needed support to manage difficulties arising from their temperament and when they needed a very firm approach to keep within limits that they were capable of achieving. Parent 1 reflected that she was not going to let W get

away with everything e.g. she said that she was just as strict with him as the other children about eating his meal and being polite while he was out. However, she identified that she experienced different **feelings** in different situations e.g. in the school trip incident, she felt he needed rescuing but that when he was just testing her out, she didn't get these feelings. The group discussed how this could be a difficult distinction, particularly when they were stressed. Parent 1 admitted that she felt that she needed the information on temperament to allow her to trust her feelings. Prior to accessing this information on temperament, parent 1 would have responded to her feelings of inadequacy and embarrassment arising from her attribution that W was being deliberately naughty rather than to her feelings of needing to rescue him.

The group discussed how important it was to have information on issues such as temperament in order that they could use their feelings effectively. They also identified the need to be able to stay emotionally neutral to think through the situation and interpret the cues and their feelings accurately. Parent 1 discussed how she felt that access to the information on temperament had enabled her to be more confident about being guided by her "feelings". This enabled her to understand how her son was feeling by helping her to consider alternative explanations, other than W was always being deliberately naughty. She also felt confident about explaining her actions to the teacher and felt that the teacher had understood. She felt that this had helped her in her relationship with the teacher as she had felt listened to and thus had stayed calm and respectful to the teacher.

However, Parent 1 questioned why she had to go through all of this as she felt that her child could be better supported if his temperament had been understood from his first day at school. The parents in this group and across the groups identified with parent

one's feeling that children such as W were not understood. They also admitted that they felt more confident about challenging systems and beliefs now that they had knowledge about issues like temperament. The feelings and experiences of parent 1 resonated across each of the 8 cohorts.

Inductive analysis with parents of Sub proposition 1.2:

That in order for carers to manage situations where their child is emotionally aroused/becoming out of control, the carers' first need to manage the reciprocal arousal they themselves feel.

Evidence which is supportive of proposition 1.2.

In the nursing research project (Croom 1996) upon which this thesis builds (see chapter 5) the nurses reported that when the child was highly emotionally aroused/angry, they as nurses also felt a reciprocal high level of emotional arousal, which they then had to manage in order to focus their emotional and cognitive resources on helping the child to contain their rage and distress.

Through analysing critical incidents with parents, where we charted on a flipchart, the level of emotional arousal of the child from getting very worked up to calming down and then charted alongside it, the parents level of arousal; it was possible to demonstrate that the experience of reciprocal emotional arousal also applied to the parents in this study. (see fig. 4) All of the 25 parents across the cohorts reported that developing this insight helped them to manage their own high levels of emotional arousal when attempting to manage their children:

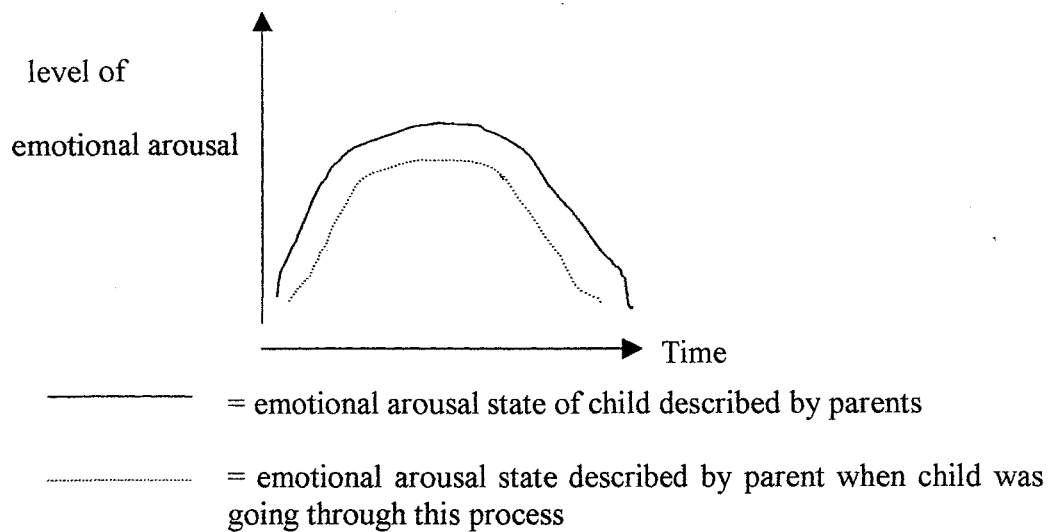


Figure 4: illustrates reciprocal emotional arousal experienced by parents and their child when child becomes frustrated and/or angry

"It helps to see it drawn out... I'd never thought about it like that before" (Parent 2 cohort 8)

"No- body has actually talked to me about this before... so I've never really thought it through it makes sense that I've got to stay calm for him to stay calm" (Parent 3 cohort 1)

Limitations to the transferability of proposition 1.2. identified by parents

Parents recognised that when their child was emotionally aroused, their own emotional arousal was influenced by multiple stressors to a significantly greater degree than the residential CAMH nurses (Croom 1996) because the "residential therapeutic milieu" protected the nurses. All of the parents across the eight cohorts expressed that extra parental stressors were related to economic hardship, lack of social support and social isolation e.g.

"If I only had him to think about, I'd be OK... he's a full time job, but I also have me other kids and it's a struggle - it's a struggle to share meself out when I've got no-one to help me" (Parent 1 cohort 5)

"I feel so down at times about everything... it's not just him- it's wondering how I can buy them new shoes- there's the worry all of the time about making ends meet"
(Parent 2 cohort 6)

Parents thus highlighted the differences between their context and the nurses' context. They described how they felt that nurses were much more supported to care because as professionals in an institution, they were liberated from any additional economic or material worries in the context of their caring relationship with the children. This discussion helped parents to identify and acknowledge the sophisticated combination of skills they had to acquire in order to deal with the multiple stressors in their lives. All of the 25 parents felt that "carers expertise" is not acknowledged and that because of this, the support they need as carers is not provided. The following sentiments were echoed across the cohorts:

"It's amazing when you think about it- I'm just meant to cope on me own" (Parent 3 cohort 3)

"It's made me realise how much I actually do But I need the school... my doctor to know this too" (Parent 3 cohort 7)

Inductive analysis of Sub propositions 1.3 and 1.4:

- 1.3. *That there is a need to recognise that carers have feelings of ambivalence towards those they care for***
- 1.4. *That acknowledging and managing ambivalence is a healthy component of close relationships***

Evidence which is supportive of propositions 1.3. and 1.4:

Sharing with parents the difficulties, which the nurses in the previous study (Croom 1996) said they had in admitting that sometimes they did not like children, even though they would always care for them, seemed to help the parents in this thesis to broach the socially taboo issues associated with ambivalence. It also helped the parents to express what all of them felt were unacceptable feelings i.e. that sometimes

they did not find their children rewarding or did not always feel that they liked their children.

"You're not meant to think like this as a parent." (Parent 1 cohort 2)

The pressure to conform to the social construction of the "ideal carer", which they felt they had been socialised into and the guilt which arose when parents transgressed these socially constructed ideals were similar to the findings from nurses who expressed that they felt as nurses that they should "like" all children equally. It seemed significant that although both the nurses and the parents found that acquiring information on ambivalence was useful to them in their roles as significant carers, it had not been shared with them prior to the research.

All of the 25 parents validated the experiences of the nurses, who found how useful it was to discuss the "normality" of ambivalence in close relationships. Parents found that when they were able to recognise ambivalence, they could acknowledge its value in galvanising their thoughts or actions in ways, which actually affirmed their love and support for their children. Numerous examples arose in the critical incident discussion and the following is illustrative of these:

Critical incident two, from Parent 2 in cohort 4, illustrates the importance of recognising ambivalence in caring relationships:

Parent 2 described how she had had a difficult week: "I've felt terrible this week. I've found myself thinking what life would be like if I hadn't had X... that I only had the girls.... but then I can't bear this thought.. I feel so guilty that I've got to do something to take my mind off it. I'll get up and I'll do a jigsaw with him just to take my mind off it and prove I love him".

Sharing and making sense of their ambivalent feelings seemed to be an empowering and cathartic experience for parents across the eight cohorts. Parent 2 admitted -

"It's good to know others feel like this.... I thought I was the only one".

Other parents in the group agreed -

"It's reassuring to hear other people talk. I used to think I must have been a terrible parent to have felt like that".

When the literature on ambivalence and the nurses experiences related to ambivalence were shared with the parents, they recognised how their feelings of ambivalence always galvanised them into positive interaction with their child, as it had done with parent 2. Furthermore, an awareness of ambivalence seemed to help parents explore their tendency to perceive themselves as "all bad" or "all good". In response to hearing this incident Parent 1 in cohort 4 described how -

"one day, you think you're great and the next you think you're crap and that everybody must be saying what a bad mother you are ... it's a killer".

Exploring the possibility in the group that mothers can cope well sometimes and not so well at other times, and using actual practice incidents from their own experiences to illustrate this, seemed to be critical in integrating their identity as mothers who were not perfect but were very loving and caring. Integrating their positive and negative experiences appeared to be particularly difficult for some of the mothers. As parent 2 said -

"I don't remember me mam ever saying anything nice about me so I find it hard to accept that I'm any good."

Helping parents to think through what it meant to them to actively value themselves whilst admitting there were areas which they would like to improve, helped to raise their awareness of the importance of a positive sense of identity. This enabled the group to explore how important this may be for their children, whom they admitted always seemed to get the blame and tended to be considered the "*black sheep*" among their peers or siblings. Helping the parents get in touch with their own feelings seemed to help provide the foundation for being able to integrate the "good" and "bad" aspects of their children (who they found difficult to manage) and to appreciate the importance of communicating the sense of acceptance, value and love, which they

themselves desired and valued, to their children, whilst not necessarily condoning their child's behaviour. Parent 3 cohort 4 admitted:

"He must think everybody is against him... that's an awful feeling for a bairn... so I need to be there for him"

Limitations to the transferability of propositions 1.3 and 1.4 identified by parents

The sense of pain and emotional arousal arising from feelings of ambivalence appeared to be significantly more intense for parents in this thesis than for the nurses in the Croom 1996 study. With parents, it was so painful and taboo that it only emerged as the sense of trust in the group grew despite all 25 of the parents eventually acknowledging that they experienced feelings of ambivalence towards their children and that they also experienced deep feelings of associated guilt. The group was the first place they had actually openly admitted having feelings of ambivalence and the parents unanimously found that sharing these feelings with the group was a helpful experience. However, parents identified that it was not enough to just develop insight into the process of ambivalence with the parents. It was also necessary to use the group to support them to be able to deal with the guilt and associated pain which arose from discussing it in order that they could then move on and use their insight to increase their capacity to respond positively to their children. To achieve this, it was necessary to help the parents to critique their assumptions underpinning their idealisation of carers. By developing a collective group consciousness, it was possible to "normalise" the feelings of ambivalence and in doing so, provide the opportunity to emancipate carers from their deep feelings of guilt.

Inductive analysis of Sub proposition 1.5:

It is essential to understand and acknowledge that children who exhibit behaviour problems often have difficulties in expressing their needs and seeking help

Evidence which is supportive of proposition 1.5.

In the nursing research (Croom 1996), nurses found that many of the children with behaviour problems had not developed the trust and confidence to ask for help and needed support to develop the skills and confidence to do this. This was checked out

with the parents' experiences. Initially the parents did not feel as though their child had a problem, with asking for help, but attributed their behaviour to being awkward and stubborn. However, through further exploration, all 25 of the parents described how they had begun to recognise that their children were often seeking their help, but in very ineffectual ways:

"He stands in front to me so that I trip over him, but he doesn't ask for anything... it drives me mental." (Parent 1 cohort 5)

"He sits and does his homework ...never asks for my help... but if he can't do something, I've noticed he taps his pencil... it's dead annoying, so I can understand why the teacher gets mad with him " (Parent 2 cohort 8)

Parents found that recognising and tuning into these cues was reciprocally beneficial to parent and child by helping the parent to recognise that their children were not trying to be deliberately annoying but needed "rescuing". This helped the parents to stay calm and work out what the child needed and so teach the child that they can ask for help and to trust that they will be positively responded to.

The parents also attempted to share this information and the strategies they found helpful with the child's class teacher. In some situations, this had a multiplier effect in which the child not only had his parent as an advocate, but also his teacher.

Limitations to the transferability of proposition 1.5 identified by parents

Parents felt that this proposition assumed that all agencies who work with children would embrace this principle of supporting children with behaviour problems, who found it difficult to ask for help. However, eight of the parents reported experiences where they had gone into school to explain their child's difficulties in expressing and seeking help, but had met with a negative response. They reported that the school had felt that all children had to learn to put their hands up to ask for help and it was not considered appropriate to make exceptions.

Ten out of the 25 parents also reported that their child's grandparents had not been supportive by recognising and acknowledging that some children needed extra help to

meet their needs. The knowledge and skills on understanding and helping a child to seek help were thus identified by the parents to be potentially limited by the lack of dissemination to and the lack of acceptance by significant external systems such as education or extended family.

Inductive analysis of proposition 1.6:

Skills and knowledge on information processing, which the nurses found helpful will be transferable to parents. Understanding how to help a child to process information in a way which enables him/her to meet developmental goals is essential.

Evidence which is supportive of proposition 1.6

All 25 of the parents supported the nursing findings (given in Chapter Five) that gaining access to knowledge on information processing literature was useful in developing their insight into how their child seemed to have difficulties in being able to inhibit their impulses or stop and think about consequences before they acted. They also found it helpful to explore strategies for helping the child to process information more effectively in order to meet their personal, social and developmental goals i.e. at school, at home and with their friends.

Like the nurses, in the previous study discussed in chapter 5, this literature on information processing had never been shared with them, but all 25 of the parents wished that it had been. Parents identified that this knowledge helped them to articulate their child's needs in ways which enabled them to be an advocate for the child by explaining their needs to others. Parent 3 in cohort 6 discussed how it enabled her to give alternative explanations to teachers about her child, who had formerly been described as a "cracker" (*Geordie for "livewire" - my italics*) or a trouble maker, but whom the parent now described as –

"a child who has difficulties with controlling his impulses." (Parent 3 cohort 6)

Parents also discussed how their children had been described as inattentive and of

"never listening to a word that is said" or "coming out with stupid things"

but following access to information on information processing/literature, they were able to see their child as:

“needing help to understand, organise and recall information”.

In addressing this problem the nurses, in the previous study, found that they needed to break down the stages of information processing into micro stages. This enabled them to make an individualised assessment of the child’s difficulties and then to offer the care and support the child required (see Chapter Five). The stages of information processing which the nurses found helpful was shared with the parents. These included:

- Being able to pause/stop and think
- To be able to think about or reflect on “What’s happening?” What does this mean? What else might it mean?”
- What do I want to happen?
- How do I feel –how can I stay calm long enough to work this out
- What has happened in situations like this before?
- Did that achieve what I wanted
- Can I do that now
- How will that make the other person feel
- Decide on action
- (Following action) did that work? Would I do that again? In what kind of situation.

The parents found that engaging in a group exercise was useful to them in understanding the implications of these different stages to information processing. They were asked to recall the last time they felt so angry, that they felt like exploding. They were then asked to reflect on this situation and to apply the above stages in order to explore how they handled the situation and whether it was effective. Parents reported that this was helpful in gaining an insight into how much information had to be processed in order for an adult to resolve situations when they are emotionally very

aroused and thus how difficult this could be for children with a range of problems such as difficulties with attention. This insight enabled them to empathise with their children and to develop a creative range of ways of providing the help that they needed:

"I used to get so mad when he came in from school I'd ask him to change out of his uniform and by the time he'd got to the top of the stairs, he'd forgotten what he's gone up for. I understand now that he has difficulties keeping anything in his head, so I get him to look at me and repeat back to me what he's got to do -then I get him to sing it all the way up the stairs- it's a laugh and he likes it ... and it works!" (Parent 2 cohort 2)

Through discussion, the parents recognised that some children needed to be systematically "taught" to achieve each of the information processing stages (which most children/ adults do spontaneously) and this reframed their attribution from

"He never listens"
to *"He needs help to listen".*

It also helped them to reflect on the amount of information they were giving their children:

"I know I've got to give him a bit of information at a time and then let him think about it. I see the penny drop and then I go onto the next bit" (Parent 2 cohort 5)

"Learning and understanding about how "A" thinks about things has helped me to think "right, I know what this is"... I give him a bit of information now at a time ...I wait and watch his face to see if he's understood... then I get him to say it back to me and if he can, I give him the next bit" (Parent 1 cohort 6)

Understanding the issues related to information processing helped the parents to recognise some of the similarities they shared with their children. This helped them to be more empathic and therefore to remain more emotionally neutral and so respond more positively with their child.

"It's made me realise what I'm like ... I always had problems listening at school... he's just like me!" (Parent 2 cohort 2)

"It's helped me to understand meself ...I feel I can help P better now-I don't get so worked up." (Parent 1 cohort 4)

The parents found that (like the nurses) helping a child to stop and think or create a "pause" was a real problem:

"He just ran out of school.... he was told at the end of playtime to line up and he didn't want to so he bolted out of the gate onto the main road.... if a car had been coming, he would have been killed, but he has no sense of danger when he's feeling like that".

(Parent 2 cohort 5)

"If you ask him to tell you how to cross a road, he can tell you, but when he's outside, he can't do it ... if he saw a friend over the road... all he would be interested in would be seeing his friend and he'd just run over it" (Parent 3 cohort 6)

Through discussion, the parents developed insight into how sometimes their child was actually trying to achieve a "pause" by attempting to get away from a situation that they were finding difficult in order to find some "space" where they could calm down:

"He takes some toys, goes to the toilet and locks himself in... sometimes he's there for an hour... but when he comes out he's calm and comes to me and says "sorry mam" and gives me a cuddle" (Parent 1 cohort 3)

However, it was acknowledged that helping a child to stop and think was a very difficult task and that it would need to continually be worked on:

"At least I understand now It won't happen overnight... I just have to keep helping him- it's bloody hard though!" (Parent 1 cohort 4)

Gaining insight helped the parents to feel more in control themselves and to focus on responding in a positive way when giving information to their child e.g. realising the importance of timing:

"I have to catch him at the right moment to talk to him, or he'll think I'm having a go at him and tell me to f.... Off" (Parent 2 cohort 5)

Understanding the information processing literature also helped parents to understand the need to provide clear limits to the children and to make these simple, short and direct to match their children's abilities.

"It's hard to remember to keep it at his level ... I have learned to watch his face to make sure he's understood and listening .. but I feel calmer when I'm doing this now... I can see why he needs it and that he's not just playing me up". (Parent 1 Cohort 4)

Introducing strategies such as that described by Cunningham et al (1995) of saying 'When... then...' helped the parents to apply limits and to do this in a way which was in tune with their child's needs by using simple phrases:

"When you said last week about using when ...then, I thought- oh aye- as simple as that is it....I didn't think it would work, but I tried it – I said ' When you've put your plate away, then you can have your sweets'- I had to say it a few times but it worked!" (Parent 2 Cohort 2)

Sharing the literature on social information processing (Crick and Dodge 1996-please see literature chapter 2 and chapter 5) which the nurses in the masters' project found to be useful, also helped parents to understand that children who tended to be aggressive or who had suffered from rejection may interpret quite neutral social cues in an aggressive or negative way. This helped them understand why the children could sometimes "go off it" for reasons that would not upset other children.

"Me mam can't understand why he takes a 'radgy' (Geordie for explodes- my parentheses) if he doesn't get his sweets first - he thinks it means she doesn't like him because he feels he comes last all of the time ... even though he doesn't. The others

don't act like that, so she thinks he's spoiled -it's hard trying to explain to her, but I'm trying." (Parent 1 cohort 5)

Insights such as this also led to discussions on how the parents themselves were treated as children and how rejection or aggression in their own past had had an impact on how they interpret things now. This helped them to develop insight into and empathy for their child's behaviour:

"I can remember as a kid thinking everybody was against me ... it made me fight them, even when they were trying to be nice... I can see how it can happen for a bairn." (Parent 2 cohort 4).

By combining the parents access to the information on both attachment and information processing the parents seemed to learn how to enjoy their children more because their insight and understanding had increased, which led to them being more emotionally available and thus to the child responding more positively to them. The parents thus gained insight into why it was important to provide positive reinforcement to their children to both develop and build their reciprocal relationship, but also to help the child to understand himself and how he can help himself to cope:

"I think we just enjoy being together more now- I used to think he couldn't wait to get out of my sight... and sometimes that was what I wanted too... we still have our difficulties but I feel closer and I know he likes it when I say good things to him... and then I feel good". (Parent 1 Cohort 7)

Limitations to the transferability of proposition 1.6 identified by parents

Although the parents unanimously found discussions and insight on information processing useful, they demonstrated how it can take varying lengths of time to help a child to process information more effectively. A critical success factor was persistence and some of the parents needed a great deal of support to maintain the level of persistence required. Other parents in the group were very effective in encouraging each other e.g.

"It does work, but you have to keep going... you feel as though it's never going to work, but it does". (Parent 3 cohort 6)

The persistence and resilience needed by the parents over a 24 hour period was much greater than the nurses required in a residential unit. To successfully persist, parents identified they needed to feel “up to it” and this depended on how tired they were and what else was going on in their lives. All parents felt strongly that they needed not only knowledge about information processing, but also extra support to keep going:

“There should be more groups like this... you need help and you need to hear that other parents are going through the same thing... you need it to keep you going”
(Parent 3 cohort 6)

“Sometimes you get so tired ... you can hardly think for yourself, never mind the bairn ... getting a break can make all of a difference ... but it's that rare” (Parent 1 cohort 7)

The application of information processing was also limited by the lack of understanding from the agencies and adults that the child came into contact with. Some parents described how they had tried to go into their child's schools to explain how to recognise when their child needed extra help and how to help:

“I tell them to watch the expression on his face. You can't miss it - he looks as though he hates everybody. I keep telling them to just leave him alone when he's like that. He goes under his desk and won't talk or do his work. They go on at him to come out and it makes him worse. I tell them that if they just let him be, he would come out of it himself but they keep telling me they can't do that because the other children would think that they could get away with it too”. (Parent 3 cohort 2)

“I've tried to explain how they need to keep explaining and repeating things for him, but they tell me he just needs to apply himself and listen!” (Parent 3 cohort 3)

Parents described how they felt that by trying to treat all children the same, organisational systems paradoxically discriminated against their children. All 25 of the parents across the cohorts felt that that the extant systems with whom the children and families were involved such as schools, which were mandated to provide a

universal service for children, were not able to cope with the individual needs of their children and instead responded to a fairly narrow set of behaviours and needs:

"You're alright if your bairn fits in ... can sit still for the "right" amount of time, can listen, and do as they're told, but god help them if they can't do this.... But I think now - my bairn's got a right to be educated too". (Parent 1 cohort 5)

Parents felt that if children were severe enough to get an educational statement or were able to conform to the range of school limits, that their needs were addressed, but that children outwith these parameters tend to get overlooked.

"They have to see to all of the bairns - not just the good ones or clever ones or those on a statement" (Parent 2 cohort 3)

The need for parents to respond to a child's need for space to calm down, when they are emotionally aroused, appeared to be much more emotionally draining for parents than for nurses in an inpatient unit. Parents felt that sometimes when their child was incredibly distressed or aroused that they tended to distance themselves from their immediate environment. This also included distancing themselves from their parents, who were desperate to help them at these times, but then felt that their child was rejecting them. The parental emotional arousal arising from this emotional-physical distancing and the perceived emotional rejection was very difficult for them to bear:

"If you try and bring him out of it, he just looks at you and his eyes are like daggers ... I get so upset ... all I want to do is help him .. but he looks as though he hates me" (Parent 3 cohort 1)

"I've tried cuddling him when he's like that, but it makes him worse ... and I feel that useless" (Parent 2 cohort 2)

"It's hard you know to deal with that rejection, especially when you're close... he does come out of it, but sometimes it takes an hour and I get really upset.. I just want to cuddle him, but he just has that evil look on his face as if he could kill me if I went near him" (Parent 3 cohort 5)

The intensity of their feelings arising from this perceived rejection was described by all of the parents. Prior to participating in the research group, the parents reported that they had felt that their child's reactions were so "unnatural", that they felt guilty as parents and so were unable to verbalise their experiences. They reported therefore that it was not just a question of having knowledge shared with them about information processing but also having the opportunity (such as the research group they were participating in) to develop a joint consciousness and understanding of issues which they previously felt to be taboo.

Refinements and additional knowledge which parents brought to proposition 1.6.

Accessing the literature on information processing and accepting the psychosocial support from the group not only seemed to help parents to cope more effectively with their children, but also to develop new solutions which were grounded in their experiences e.g. parents identified some novel ways of testing out to see if a child was ready to calm down and be accessible so that they can talk through a situation:

"I just plod around doing whatever I do, but I keep checking him through the door. When he's sitting there with eyes like daggers, I know I've got to leave him alone, but when I look and his eyes go down in a smile, that's when I know he's OK and then he comes around and says "sorry mam" and gives us a cuddle, but before that the expression on his face.. it's really terrible... evil... all kinds of things go through your mind when he's like that" (Parent 3 cohort 4)

"I can tell if he needs to be left alone... I tickle him and if he tells me to get off and looks as if he hates me guts, I know I've got to leave him alone, but if he laughs, I know I can get him out of it" (Parent 2 Cohort 2)

Other parents found it helpful to hear these strategies, which also helped them to deal with the waiting time until their emotionally aroused and distressed child could become emotionally available to them again.

The pain of the perceived rejection by their children and the sense of guilt the parents felt about feeling ambivalent, which all parents identified they initially felt about their child at the start of each cohort, also helped the parents (and indeed the group

facilitators) to understand why it was so difficult to apply advice from traditional parenting programmes such as Cunningham et al 1995 and Webster-Stratton 1998 on withdrawing attention from the child when they were behaving inappropriately. However, understanding the underpinning principles helped parents to apply these principles in a more effective and emotionally neutral way:

"It used to be so hard to ignore him- I'd feel that guilty about him being so upset or sometimes so bloody angry with him that I'd argue with him ... I'm getting better and I know it can work- but it's still hard". (Parent 2 Cohort 7)

Inductive analysis of sub-proposition 1.7:

Knowledge and skills on peer relationships which nurses found useful in an in-patient setting will be useful for parents

Evidence to support proposition 1.7

Nurses in the earlier study found that in a structured in-patient setting, they could use their special relationship with the child and the properties of the in-patient therapeutic milieu in order to help children with peer relationship problems. Nurses used all of the child's interactions as potential learning experiences to help the child develop a sense of empathy and self awareness which provide the platform for building peer relationships (See Chapter Five).

The parents in this thesis also identified that their child had significant peer relationship difficulties involving being frequently rejected by peers and only being able to sustain short periods of play without getting into trouble. All of the parents described how other children quickly realised how easy it was to wind up their child. They also described how their children often hung out with older children, rather than peers and that this meant that they were more likely to get into trouble. Parents recognised that the skills of supervising the child's activity, structuring their play and helping their child to learn how others feel were essential to promoting positive peer relationships but were also much more difficult to implement in their setting than the nursing setting, where the staffing ratios meant that supervision of the children was continuous and consistent and the mix of children admitted to the residential unit was strictly controlled to maintain a therapeutic atmosphere.

Limitations to the transferability of proposition 1.7 identified by parents

Parents had greater difficulty applying the skills and knowledge on peer relationships than nurses for a variety of reasons e.g. they had other children, who demanded their time and attention, the structure of housing estates meant that constant supervision was difficult and this meant they could not always physically monitor and control interactions throughout a child's day.

Section Two: Inductive analysis of proposition 3:

That parents can increase their capacity to respond effectively to their children with behaviour problems by gaining access to a diverse body of knowledge and by being participants in the knowledge production process.

Section one provided an analysis of the behavioural and action propositions set out in Box 4 and 5 pages 219 and 233). It illustrated how parents were able to develop their skills and confidence through gaining access to a diverse range of knowledge and group support. However, it also highlighted the enduring difficulties which confronted the parents that could limit their capacity to care effectively for these children and how these psychosocial stressors can constrain their capacity to utilise CAMH information.

Section two focuses on the development of the parents' capacity to respond to their children following their participation in the research. Findings from group discussions and the analysis of critical incidents and reflective action cycles will be presented to illustrate how the capacity of the parents to respond to their children changed as a result of participation in the group and research process. Findings will also be summarised from a short questionnaire (Appendix 8) given at the beginning and end of each cohort in order to gain parental evaluation on how they perceived their capacity to respond to their child had changed over the course of the participative action research programme. The questionnaire focused on how parents felt they understood their child and felt connected to their child, how they were able to disseminate information about their child to significant others and how they felt they coped with their child following participation in the group.

Through their joint exploration of critical incidents and action learning cycles, parents appeared to access group support and to develop a group identity. This helped them to recognise their own strengths, acknowledge their needs, to build their capacity to challenge the systems that their children were growing up in and to articulate their previously intuitive parenting expertise.

Evidence Supportive of proposition 3.

Critical Incident three which illustrates development of parental capacity through participation in research process and recognition of strengths

Critical incident three will be used to illustrate how the research process and the combination of methods helped Parent 1 in cohort 6 to increase her own capacity and that of the other members of cohort 6 by acknowledging her strengths and developing solutions within the group.

Critical Incident three

In cohort 6, parent, 1, came in on week five feeling distraught because of an incident in school, where her son (E), a temperamentally challenging, impulsive 8 year old had become frustrated and then aggressive to the point that the school did not feel that they could cope and so had telephoned parent 1 to ask her to come in and take L home. Parent 1 got the message late in the day and so had hurried to the school in a state of high anxiety.

She described how her first reaction on seeing her son in the head's room (where he had upturned tables and chairs) was to swear at him "what the f... do you think you're doing?" Parent 1 described how she felt anxious, guilty and "shown up". She admitted "I know it was the wrong thing to say, but I'm human". She described the sense of disapproval she felt that came from the teacher about her swearing. On initially recounting the incident she was angry with the school and herself and feeling a failure as a mother.

Exploring the critical incident with Parent 1 cohort 6 and the rest of the parents in cohort 6 provided an opportunity to inductively analyse how useful the knowledge and skills derived from the nursing research (Appendix 1 and Box 5) were to parents in cohort 6 in their everyday context. At the same time it provided opportunities to articulate their parenting skills, which they had previously taken for granted or not been aware of.

When asked what she had done after she had sworn at her son, Parent 1 described how she had realised that his teacher was frightened of her son and this was being communicated non-verbally to him. Parent 1 reported:

"She was standing behind me as if she was trying to use me as a shield - I knew he would be worse if he thought the adults were scared of him".

Knowing this about her son, Parent 1 went up to him and stood close to him and said:

"Haway now-that's enough".

In the group, we explored the tone of voice, which she had used at this point and established that it was authoritative, because she had said it firmly but calmly. It was thus possible to discuss with the group how Parent 1 had skilfully tuned into and responded to her son's needs to be contained at this point by an adult, who could take charge and she had intuitively responded to his needs through the tone of her voice and her body language. It also presented an opportunity to explore the benefits of staying calm, despite the very high emotional arousal which parent 1 felt in order to be able to "tune into" the child's needs. She acknowledged that although she hadn't realised it, she had displayed many of the skills identified in the behavioural propositions given in Box 5. On discussing the consequence of her behaviour, Parent 1 admitted that she felt that it was at this point that her son did in fact start to calm down and that she was feeling calmer too.

She (parent 1 Cohort 6) described how the teacher sensed this and then started trying to engage him in a verbal discussion about his unacceptable behaviour. He started to get excited again and his mother explained to the teacher:

"Divn't talk to him now - ye'll set him off again. He needs a bit of space to calm down".

Again it was possible to use this as a basis for the group to explore how Parent 1 had tuned into her son's needs Parent 1 was and how she then used this to be an advocate for him and to guide his teacher's behaviour.

At this point, it was possible to inductively analyse the proposition about information processing within the group. Parent 1 agreed that she had instinctively recognised that when her child was emotionally very aroused, he had difficulties processing information and needed time and space in order for him to become receptive to any discussion about his behaviour. While he needed this space, she withdrew her attention – she did not speak to him, because she sensed that he was already so over aroused, that he would not be accessible to any words or contact from her. She felt that becoming aware of the literature on information processing was helpful to her, because she could now use it in the future to explain her child's needs to his teacher and others in a way she would not have been able to previously.

Once L was calm, the teacher exited the room, leaving Parent 1 with her son and within about 10 minutes, she was able to negotiate with him that he was going to leave school with her. By this time, it was the end of the school day for all of the children. At this point L was calm and Parent 1 felt that the situation had resolved. However, as they left the school, she described how the teachers had lined the school children up in such a way that they were separated off from her son and she remarked:

"He's only 8- but you'd have thought he was public enemy number one".

On seeing this and sensing the tension, L nearly erupted again but Parent 1 stayed close to him, held onto his arm and managed to get out of the school without further incident. However, she described how she had felt very angry, humiliated and as if everybody at the school had been looking at her and judging her. She also felt angry that the school system was unable to cope with her son, but expected her to. She had asked for him to undergo a statement for special needs, but was told his behaviour was not severe enough to require this.

The other parents listened intently and were able to reinforce Parent 1's skills and reflect on how they could use them. Thus this critical incidents provides an exemplar of how using the incidents from parents everyday experiences provided parents with an opportunity to engage in a reflective action cycle in which they inductively analyse how useful the nursing propositions which reflected actions and behaviours (box 5) were in making sense of and managing the situation as well as identifying Parent 1's tacit knowledge and skills and thus developing her sense of competence and using these as a platform to recognise and develop other skills among the group members.

As discussed in Chapter Three critical social theory requires an analysis of not just what is, but what needs to change. To achieve this it is necessary to analyse the underlying social assumptions embedded in everyday incidents and encounters such as the one described above. Through discussion the parents were encouraged to explore the assumptions underlying the behaviour of professionals as represented in this incident.

The parents identified that this incident illustrated how they were unwittingly confronted with a range of socially constructed assumptions that impacted heavily on their and their child's lives. Examples of such assumptions included 'that unless children with challenging behaviours could earn a "label" of special needs for an educational statement, that they must be "bad" children from "bad" parents'. The parents explored how things could change and what "might be" instead of "what is". They agreed that access to 'legitimated information' arising from literature and research was useful because they could disseminate this and also use it to challenge tacit socially constructed assumptions, particularly in schools.

However, they also felt that a wider systemic change was required in order to recognise and respond to the wide range of children's needs e.g. parents felt that if schools could be educated and resourced to cater for a diverse range of needs, then there would be a reduction in the blame imposed on parents. They also felt that the degree of care, which they, as parents, were expected to give, should be acknowledged. For instance in critical incident three given above, the parents recognised that Parent 1 above was expected to cope better than a well trained and relatively highly paid professional. As a result of the group discussion, Parent 1

reported how she had gone into the school to talk the situation through with L's teacher. She described how she felt really good about herself that she had done this without losing her temper.

Findings on risk and resilience

As the literature chapter indicates, the concepts of risk and resilience provide an influential evidence base informing practice in CAMH. The findings from the data collected with parents will now be analysed in the context of this literature.

Critical incidents such as that discussed by Parent 1, cohort 6 in critical incident 3 above, highlighted the strengths which parents had and how these could be developed but also highlighted the vulnerability of the parents and the stressors they experienced.

Table one (given in Chapter Four) illustrates that 24 out of the 25 parents were lone parents. Only one parent was a home owner and the rest of the parents lived in rented or council accommodation, which was not adequate in terms of space and facilities for their children. Twenty four out of the 25 parents were living on social assistance. Parents described how all of these factors caused stress and had an impact on how emotionally available they could be to their children with challenging behaviours:

"It's hard to keep your temper, when you're running short of cash and the next giro is 4 days away." (Parent 3 cohort 5)

However, through discussion the parents began to recognise their own strengths, which helped them to cope when times were tough. They demonstrated a range of strengths including:

- A good sense of humour
- Resourcefulness in managing their homes. Many of them were proficient decorators and cooks, who took a pride in managing their homes as single parents on a very low income
- They had enough confidence to take a risk and attend the group even though it was out with their usual experience.

- They were able to show empathy and support each other
- Although educationally disadvantaged, all eventually demonstrated that they could use information to help them problem solve and develop solutions
- They were all devoted to their children

The emergence of the profile of parents' and children's strengths and needs occurred in the first cohort and similar patterns were repeated across the eight cohorts. These discussions led to a comparison of the parenting experiences with the literature on risk and resilience literature. Findings from the risk and resilience literature (see Literature Chapter 2 and Appendix 9) were then shared with parents to explore how useful the parents found the literature on risk and resilience, when applied to their everyday lives (see appendices 7 and 8). Parents found the risk/resilience literature helped them to recognise not only their own strengths but also their child's strengths. Twenty out of the 25 parents across the cohorts recognised that their child had a very loving nature, 15 recognised they could be really good fun to be with at times and all 25 of the parents recognised that their commitment to their children was their child's greatest strength. Although risk and resilience literature had been around for over 25 years, it had not been made available to the parents, despite how useful they found it in this thesis:

"It helps to see how much you're doing right instead of all the things you're doing wrong" (Parent 2 cohort 8)

"It helps makes sense of why he finds things more difficult - and explain to the teacher how to think about him as a little boy with needs... not a monster" (Parent 1 Cohort 3)

The work on risk and resilience thus seemed to help the parents increase their capacity to respond by systematically identifying their strengths and building on these as well as identifying their families needs and ways of dealing with them.

The following critical incident illustrates how the group helped the parents identify ways of acknowledging and building on their resilience through tuning into their

children, acknowledging their temperamental traits, tuning into them at times of crisis and responding to them sensitively.

Critical incident four from Parent 2 in Cohort 6 illustrates how participation in group helped parents to recognise their own strengths and those of their child.

This example involved Parent 2 with her little boy J, whom she initially described in very negative terms. Parent 2 described how the previous weekend, J had been driving her mad and so she sent him to a room with a friend "I just wanted him out of my hair for a while". When asked if this worked, she was able to say "well, it did, while he was up there". On further discussion, it was possible to discuss the little boy's temperament. J needed constant activities, diversion and stimulation. However, he was better with friends around him. It was possible to reinforce parent 2's skills of recognising the value of friends for her son. She was then able to discuss what a popular child he was and we were able to discuss in the group what a good sign this was (both from the point of view of resilience literature, but also experientially). Thus the group were able to help this mother to recognise some of her son's strengths. It was also possible to discuss how she had tuned into the little boy getting over-excited downstairs and to recognise that he was unable to control this, but when he was upstairs, he could enjoy his friend's company in a more contained environment. Parent 2 thus began to recognise her strengths as a parent and how she was acutely intuitively tuned into her child. The following week, she reported that things were getting better "because I can predict him more now".

Change in Capacity of parents in each cohort to challenge the facilitators and question the status quo.

In order to ensure that the research was operating within participative action research principles, it was crucial that parents genuinely felt able to challenge the facilitators and the propositions they were putting forward. As discussed, the facilitators

reinforced with parents at each session, the importance of their challenges and disagreements and that this provided data that was equally, if not more important to the data collected than when they supported the propositions. As discussed in the first section of the findings, there was a recurrent pattern in the themes which emerged across each cohort, including the themes which parents identified supported the propositions, the themes indicating when the parents disagreed with propositions and the proposals made by parents as to how they could refine the propositions.

However, there was also a significant pattern which emerged in the change of the group dynamics in each of the cohorts. When parents came to the group initially, they exhibited a low sense of self-esteem and a lack of confidence in their problem solving capacity. They were suspicious about the group, expecting to be judged and not wanting to disclose anything which could be construed within the group as socially unacceptable behaviour. This was initially manifest by being quite dependent on the group leaders and looking to them in discussions for guidance and solutions. As the group progressed, they made more eye contact with each other and initiated more dialogue with each other. A significant step forward was when they began to challenge the group leaders and actively engage in inductive analysis /critique of issues being explored. In doing so, they illustrated that they had moved from a vulnerable position of dependency to peer support to autonomy and thinking for themselves. As the group sessions progressed, there was a significant growth in the number of solutions produced by the parents to the different problems which arose and a more spontaneous application or critique of the information which had been shared with them. Although there was homogeneity of the themes which emerged across each cohort, the parents were able to provide more critical analysis of the propositions as the group sessions progressed.

The following critical incident (5) illustrates how a combination of disseminating knowledge and providing an opportunity for the parents to develop skills helped to identify and reinforce strengths and resilience in the group. Critical incident 5 was given by of Parent 3 in cohort 7 to illustrate how participation in the research process helped parents to promote their resilience at both an individual, group and community level.

In cohort 7, week 6, Parent 3 arrived late and clearly needed some support to talk about her problems. She felt that she had been harassed at the social security department and was feeling fed up about her diet. Prior to the group she had been a heavy smoker and following a diagnosis of diabetes, was seeing her GP for obesity. She was in inadequate housing and was trying to cope with a behaviourally and temperamentally very challenging little boy. Her strengths in problem solving how to lose weight and stop smoking whilst dealing with these extremely difficult circumstances had been previously discussed and acknowledged in the group. This week she got immediate encouragement from the group to maintain her no smoking programme and at the same time, to keep to her diet. The parents in cohort 7 helped Parent 3 with her flagging self esteem with reinforcement such as "Aye, I thought I had will power, but that I couldn't do that - give up smoking and diet at the same time especially when you've got all that other stuff to deal with". This comment was given by a very strong member of the group and so had lots of authenticity. Parent 3 was then able to talk about the council's plan to demolish her current house and rehouse her in more suitable accommodation. The group helped her to see that some good things were happening in her life, despite the harassment. The group then spontaneously tried to help her problem solve how to get the house she wanted. She had seen the house, but was waiting for final confirmation of demolition of her current house before acting.

Parent 1 suggested being proactive and going to the council to see whether this house had been allocated or not. Parent 3 said how she felt she would not have been able to do that before but felt now "I've come so far... I feel I can give that a go now". The group was thus able to model problem solving and being assertive (both of which had been discussed in previous groups as examples of factors which helped to develop resilience). Initially in the group, Parent 3 used to come in and always sit outside of the group, looking extremely miserable and saying very little but now she actively engaged in the group and was able to access the support it offered to cope in her everyday life. As her own self esteem developed, her ability to tune into her child seemed to correspondingly develop.

Later on, in the same group session, the topic of temperament re-emerged. Parent 3 was able to illustrate to the group how she had used her newly acquired knowledge

about temperament to make sense of her child's (M) behaviour in the past week. M. had started to get very upset at school because his class were now expected to line up with the other classes at the start of the day and at the end of break time (Prior to this, they were allowed into the classroom first without any wait). Parent 3 described how she now recognised that this was a major change in routine for M and that instead of getting upset or blaming the school as she would have done previously, she realised he would take longer to adapt to the change and was able to talk to his teacher about it. Her insights thus provided a platform to discuss in the group how children with a difficult temperament found changing activities more difficult. The group were also able to integrate material from the previous week to discuss how children like M who have a more challenging temperament,, find sitting still, focusing and being content much more difficult than a child with an easy going temperament.

Through the discussion of the critical incident of given by parent 3, the parents in cohort 7 were able to acknowledge what a strength and support it was to their children that they had parents who were so dedicated to becoming tuned into them. The parents also identified how much they were acting as advocates for their children by going into schools and explaining their child's needs. They felt that gaining an understanding of temperament and the confidence gained thorough the group enabled them to be a significant component in increasing the community capacity to respond to their children e.g. it helped them to proactively work with their schools (with whom there had previously been fraught relationships) and to actively share with the teachers the techniques, which they found helpful in managing their children. In Parent 3's case, this involved explaining how her child needed some space if he gets frustrated, where attention is withdrawn from him, so that he could calm down and become accessible to his teacher's help. Before the group his inability to listen, when he got highly frustrated, was attributed as deliberate naughtiness. Through having his needs met more effectively, M's strengths were developed e.g. he became more emotionally available to his mother and his teacher. This promoted more positive relationships, and increased M's sense of confidence. This both enabled Parent 3 and her son begin to develop a pattern of resilience in place of the escalating cycle of vulnerability, which had previously been developing. However the above incident also demonstrated the capacity of the group to not only develop solutions related to the children and their extant systems such as schools, but also wider psychosocial

issues such as housing and in doing so, how to build systemic resilience within the group.

CHALLENGES TO FACILITATORS AS PARENTS BECAME MORE CONFIDENT AND SECURE IN GROUP SETTING

The group demonstrated their increasing capacity to challenge within the research. During their 6th week, they challenged the group facilitators on why the information they brought to the group was not disseminated within schools as they felt it should be:

"It's not just us who needs to know this - are you going into the schools with this information?" (Parent 1 cohort 7)

This direct questioning was initially uncomfortable for the facilitators, but we quickly recognised through reflection and supervision, that it was an essential component of both the group and research development and represented significant data about the resilience and strength of both the parents and the group. A pattern, which emerged across each cohort therefore, was how the parents gradually began to think through solutions not only at an individual or family level, but also at an organisational and systemic level as the groups progressed. They were also able to question and refine the usefulness of the propositions and literature e.g. by articulating how the stress of neighbourhood harassment (discussed earlier in the findings) increased their vulnerability to developing problems. They were also able to challenge and suggest to the group facilitators how they felt the system should be rather than what is e.g. that information needed to be disseminated not only to parents but also to GP's and schools.

Limitations to the transferability of proposition 3 identified by parents

As identified above, the parents increasingly were able to question and challenge and were thus able to highlight that there were limitations to the degree to which gaining

access to a diverse knowledge base and the research process can influence the capacity of the parents to respond to their children with behaviour problems.

They illustrated that developing their capacity to respond to their children is not only dependant on their own strengths and efforts or of their increased awareness of knowledge such as risk and resilience factors but that a total systems response is required in which all of the extant systems with which they were involved such as GP's, schools and recreation facilities are aware of the total set of their children's needs. They also demonstrated that a societal and policy response is also required. For instance, the evidence base demonstrates the importance of recreation and extra curricular activities in helping children to cope and stay healthy despite adversity (Browne et al 1999). However, when this research was shared with parents, they identified that in their experience, the cost of recreation was prohibitive to parents, like them, who were on a low income or income support. This means that policy changes and a joint understanding across agencies are necessary in order to develop systemic capacity and to maximise the protective factor of recreation. The following critical incidents are used to illustrate this.

Critical incident six provided by Parent 1 in cohort 1 illustrates how the resilience of families and their capacity to respond to children with challenging behaviours can be increased through the provision of recreation:

K, aged 9, had significant problems containing his frustrations and would often explode and hit out. His challenging behaviours had progressively got him into trouble at home and school. During discussions in the group, his single parent mother identified that he was a very sad little boy, who thought he was useless and perceived he always got the blame from adults. The only time he had seemed to develop some confidence was in judo, in which he did very well. However, he needed a new judo suit. His mother could not afford it and he refused to attend without the suit. The group attempted to problem solve this situation. They began to challenge the group facilitators to ask what they could do about this. This made us reflect on our positions as nurse practitioners in CAMH, who provided 'therapies' to exploring how we could provide a total systems approach. As a result of this, my own practice was developed and I successfully made an application to a charity, to acquire a second hand judo

suit. This made a big difference to K and his mum's relationship. He felt she had made a big effort to be on his side. He subsequently won a judo prize and gained in self-esteem, which began to have positive effects both at home and school.

Critical Incident seven given by Parent 1 in cohort 2 illustrates that a policy change is required to implement the evidence base which describes the importance of recreation in reducing risks and developing resilience:

In cohort 2, Parent 1 described her son R, aged 8. They lived on a tough estate, where there was a high degree of crime, vandalism and delinquency. R's problems were severe enough to have warranted a referral to the specialist CAMH service waiting list, from which he was recruited for the research. R was easily led into trouble by older boys if he was allowed out to play, but his high levels of energy and distractibility meant that he needed to be involved in structured, high energy, focused activities. His mother was very supportive of him, but she was a single parent caring for three other children. If R stayed in the house for long periods, there were tensions with siblings, which increased the stress on whole family. Prior to the summer holidays, R had been involved with some older boys, who committed a burglary and as a result of this, he was taken to the police station. His mother was very distressed at this and discussed it in the group.

One of the parents advised getting him a bike. His mother (Parent 1) thought this was a good idea, but could not afford it as she was going to have to buy new sets of school uniforms over the summer. The group again challenged the facilitators, pointing out that they were the sort of parents who needed support, but that it felt to them as if they were banging their heads off a brick wall. Through a contact with a social services colleague, I was able to make an application to a charity to successfully obtain a second hand bike.

At the time, I had misgivings about doing this again as I did not want to either create dependency or to reinforce the idea that as a professional, I had the extra power to obtain resources. However, there was no other way for the parent to make an application to obtain the bike from health, social services or voluntary charities. Acquiring the bike had many positive therapeutic outcomes for the family:

- 1) *R did not get into trouble with gangs as he did not want to leave his precious bike anywhere on the estate as he feared it would be stolen. He also began to learn a sense of responsibility and planning ahead by taking care of his bike and making sure he would not have to leave his bike around.*
- 2) *He was able to use up his energy riding around and trying out "stunts" this helped on occasions to let him play with more pro-social peers who were also interested in bike stunts.*
- 3) *When he was out with his bike, it gave him a break from the house and he returned in a better mood and so relationships with his mother and siblings improved. This in turn improved his self-esteem.*
- 4) *He stayed out of trouble for the summer holidays and learned that he could enjoy himself in alternative ways from risk taking behaviour with older boys.*

As a child and adolescent mental health professional, the therapeutic outcomes, which appeared to be achieved through the provision of a second hand bike and judo suit, were more than I could have expected through weeks of therapy. In combination with the groups it allowed parents and professionals to learn and experience the benefits of recreation in terms of providing a normalised route to adult supervision, self-esteem, and skills building. However, it was not always possible to facilitate relevant recreation e.g. transport and entry costs could not be met through routine or charitable funding. The parents thus highlighted for me the paradox in which as a professional, I could offer relatively expensive therapeutic support, but found significant barriers to providing for needs identified by the parents, which constitute cheaper alternatives. In order to increase the total system capacity, the parents demonstrated that it was potentially cheaper and more effective to listen to the family and respond to the actual needs they were identifying, but that the system in which I worked appeared to militate against this, by asking which service (if any) could be provided.

Parents also reported housing difficulties, which limited the ability of the parents to have the resources and emotional availability to increase their capacity to respond to their child through access to knowledge and research alone. They identified the need to provide safe spaces for the children to play in inner-city areas e.g. gardens where the children could be supervised. One mother, who had recently moved into the city from a small country town said:

"Life was easier where I was. S needs a lot of space... where I used to live, we had a garden, but I only have a yard now and it leads onto a main road. When I take her to the coast and she can run along the beach for hours, she's fine, but I can't do that all of the time." (Parent 3 cohort 5)

Evaluation of the Parenting Groups

The next section will discuss the findings from the questionnaire (Appendix 8) given to the parents at the beginning and end of each cohort. The questionnaire explored how becoming part of the research process influenced the parents' capacity to care for their children by exploring how some of their risk and protective factors, associated with challenging behaviours had changed from the beginning to the end of the group sessions. These factors included: the ability to understand and connect to their children, which is related to attachment; the ability to care for and feel that they can cope with and manage their child, which is related to the family capacity to problem solve and develop competence and the ability to discuss their child's needs with others and to feel supported in their parenting role, which is related to their ability to access supportive social networks. (Please see appendix 9 for detailed findings from questionnaire).

As the questionnaire is used as a tool to measure the change in the parents, who participated in the research, the results are given for the 25 parents who attended the first and last session in each cohort. These were also the parents who attended 75% of the sessions. The 20 parents who attended the first session across the 8 cohorts but did not attend any other, reported similar themes and content to the 25 parents who participated.

Appendix 9 gives the results of the analysis of this questionnaire. This section incorporates key tables from Appendix Ten which inform the findings of the research.

All 25 parents across the eight cohorts reported a positive change in understanding their child to some extent. Access to the group seemed to have an impact on the extent to which they felt in tune with their child as all parents reported feeling more in tune with their children in the last session of the groups compared to the initial session. This questionnaire data triangulated with the data from the group discussions and critical incidents, when parents indicated that access to literature such as information processing helped them to understand their child better.

Table two indicates that all of the parents across the eight cohorts thought that their ability to predict their child's behaviour had improved, but they still indicated that they could find the child's behaviour unpredictable. This triangulated with the group discussion and critical incident data, when parents recognised that their children were all temperamentally very challenging children and so continued to manifest difficult, unpredictable behaviour but the parents felt more connected to their child as a result of being part of the group.

Table Two

I feel I understand my child's behaviour (1 = high score 5 = low score)		
Findings at beginning of cohort		
4	16%	Parents scored 5
18	72%	Parents scored 4
3	16%	Parents scored 3
Findings in last session of each cohort		
2	8%	Parents scored 4
19	76%	Parents scored 3
4	12%	Parents scored 2

Table three indicates that all parents felt that they were less likely to get wound up by their child's behaviour at the end of the group sessions, although it still happened on a regular basis. This triangulated with parental discussion and critical incident analysis, which indicated that their ability as parents to stay calm and neutral was not just dependant on information, but on a whole range of psychosocial factors.

Table Three

I feel in tune/connected with my child (1= high score, 5 = low score)		
Findings at beginning of cohort		
1	4%	Parents scored 5
5	20%	parents scored 4
18	72%	Parents scored 3
1	4%	Parents scored 2
Findings in last session of each cohort		
21 parents	84%	parents scored 3
4	16%	Parents scored 2

Table Four indicates that when asked if they enjoyed being with their child, there did not appear to be any change from the beginning of to the end of the group sessions. However, they all admitted that they had felt too guilty to say in the first session that

they did not enjoy being with their child very often. In verbal reports, through group discussions, all of the parents across the cohorts reported that they enjoyed being with their child more at the end of the sessions than they had at the beginning of the groups, but admitted that there were still times when they found being with and managing their child was very difficult. It could therefore be that the score at the end of the session was a more accurate reflection of how they were feeling. This triangulates with group discussions on the socially taboo nature of a carer feeling ambivalent about their child and the critical incident data which indicated that parents initially felt guilty for not living up to their 'idealised carer role'. However, by becoming part of the group, the parents were able to develop a joint consciousness which allowed them to challenge the social taboos and the myth of the idealised parents and thus to acknowledge their true feelings.

Table Four

I enjoy being with my child: most of the time /often / sometimes / not very often/ find it difficult Findings at beginning of cohort		
25	100%	parents said sometimes
Findings in last session of each cohort		
25	100%	parents also said sometimes

Tables five and six indicate that all of the parents in each cohort reported feeling more supported and less isolated at the end of the sessions, although they still did not feel fully supported.

Table Five

<i>I feel supported as a parent</i> <i>1 = high score 5 = low score</i> Findings at beginning of cohort		
5	20%	Parents scored 5
17	68%	Parents scored 4
3	12%	Parents scored 3
Findings in last session of each cohort		
2	8%	Parents scored 4
19	76%	Parents scored 3
4	16%	Parents scored 2

Table Six

I feel isolated as a parent 1 = high score 5 = low score		
Findings at beginning of cohort		
17	68%	Parents scored 5
8	32%	Parents scored 4
Findings in last session of each cohort		
2	12%	Parents scored 5
22	88%	Parents scored 3

Table seven indicates that all parents reported at the end of the sessions, felt more able to manage their child, but indicated that it could still be difficult. This triangulated with the critical incident data, which indicated that the parents' capacity to cope was dependent on many factors such as school attitude, their own feelings of stress and not just what we had discussed within the group.

Table Seven

I usually feel able to manage my child's behaviour 1 = high score 5 = low score		
Findings at beginning of cohort		
1	4%	Parents scored 5
2	8%	Parents scored 4
22	88%	Parents scored 3
Findings in last session of each cohort		
22	88%	Parents scored 3
3	12%	Parents scored 2

Table eight indicates that when asked if they could explain their child's behaviour better to others, parents felt that the group discussions and the access to information had helped them to explain their child's behaviour better to significant others, however the improvement was small and indicates the need for wider dissemination of this information to reinforce the mothers understanding.

Table Eight

<i>I feel I can discuss how to manage my child's behaviour with my partner/mother/auntie etc.</i> <i>1 = high 5 = low</i>		
Findings at beginning of cohort		
22	88%	Parents scored 3
3	12%	Parents scored 4
Findings in last session of each cohort		
24	96%	Parents scored 3
1	4%	Parents scored 4

Table nine indicates that 24 of parents reported that they felt more confident about approaching teachers at the end of the sessions compared with the beginning, and some felt that the teachers listened, but eight parents still felt that although they were able to explain their child's needs better, the school were unable to take this on board. This triangulated with group discussions and critical incidents which indicated that it was essential that parents had not only access to the information and support, but also that significant others in the extant systems with which the child and family interacted had access to information and support. This included professionals such as GP's and teachers as well as their extended families.

Table Nine

<i>I feel my child's teacher is supportive</i> <i>1 = high score 5 = low score</i>		
Findings at beginning of cohort		
18	72%	Parents scored 4
6	28%	Parents scored 3
Findings in last session of each cohort		
5	20%	Parents scored 2
12	48%	Parents scored 3
8	32%	Parents scored 4

The findings from the questionnaire thus seemed to support the overarching findings from the group discussions and critical incident analysis that although the capacity of the parents to respond to their child was enhanced through engaging in the groups and

the research process, this was not in itself sufficient to enable the parents to implement the knowledge and skills identified during the nursing research as core to helping children maintain control throughout the 24 hour period. Increasing the overall capacity of the parents to respond to children with significant behaviour problems also required a range of psychosocial support and co-operation from significant others including teachers and grandparents in the extant systems with which the child and family interact.

Section Three – Findings from the inductive analysis of Proposition Four:

That service planners and providers can utilise parental knowledge, expertise and insight into caring for children with behavioural problems throughout their 24 hour life span in order to increase the total systemic capacity to respond more appropriately and effectively to the needs of these children

Evidence which is supportive of Proposition Four

The parents identified a range of strategies, which they felt helped them to find and develop an emancipated voice. The parents felt that parenting groups provided opportunities which helped parents to develop a joint sense of identity and confidence and an alternative consciousness/viewpoint. This enabled them to build on their skills, challenge the status quo, develop a vision of “what could be” instead of “what is” and propose ideas for change:

“I don’t feel as though I have to put on a front- I know that there are other parents feeling what I’m feeling” (Parent 1 cohort 1)

“This group gives me the chance to say how I feel - I’ve kept it in for that long” (Parent 1 cohort 2)

“I think our children need to have support like this... this has made me realise how they get so left out... at school... by the kids at home” (Parent 3 cohort 2)

"I realise it can't just be me, because there are other people here. I can't believe it when another parent talks about their child and I think-that's amazing-that's him (Child) ...that's me-that's how I feel" (Parent 2 cohort 4)

"I feel more confident... now I understand things better- I think I've done bloody well- I don't sneak around so much now trying to get things done before anybody notices us... sometimes I'll explain why he has problems and sometimes I think -you can think what you like, because I know I'm doing me best" (Parent 2 cohort 6)

"I feel I can come here and people will actually want to listen to me... I feel that for the first time, someone understands what it's like...I feel people care....I can get through the week better, because I know I'll have a time to get things off my chest" (Parent 3 cohort 7)

"I don't react every time the neighbour comes to the door now - I try to stay calm and listen- but I don't accept straightaway that it's my child's fault". (Parent 3 cohort 8)

"I feel OK now about going to speak to the teacher - I think well, my son's got as much right to be educated as the others..... I try and talk to the teacher about the kind of help he needs - I realise I have to stick up for him because no-one else will" (Parent 2 cohort 8)

"It makes a difference if you go into school and you start talking about "temperament" as if you know what you're talking about" (Parent 3 cohort 3)

Critical incident eight provided by Parent 3 in cohort 5 illustrates the importance of parenting groups as a strategy to increase systemic capacity by helping parents cope, develop resilience and to challenge their extant systems.

In cohort 5, a mother, Parent 3, was profoundly distressed and tearful because of "hassle" she was getting from neighbours. She felt as though she was becoming more marginalised on the estate. Her son was not being asked to other children's houses any more, she was getting neighbours calling at her door to complain and she felt as if she was the subject of much gossip.

This made her feel as though her neighbours perceived as a bad parent. This was very difficult for her to deal with as she had had a difficult childhood herself and was determined for her children to experience a better life than her life had been.. The group were helpful in acknowledging her quite heroic efforts to help her son and his behaviour and were able to empathise and support her in a way no professional could. One of them said, "Look hinnie, you're doing your best ...the problem's not yours, it's theirs" Another parent identified with this mother's situation and explained that her way of coping with these situations was to imagine that the complainant at the door was standing naked in front of her because she felt that this reduced the impact of their words and their attitude. This was greeted with great hilarity by the group. The whole approach of the group was very warm, supportive, empathic and non judgmental. The combination of empathy and humour appeared to match the kind of help this lady needed at the time. The following week, parent 3 returned looking physically and psychologically brighter. She reported that she had had the confidence to go out for a night with the neighbours, which had been planned for some time and which she felt unable to get to in the previous week. She reported that she projected such confidence to her neighbours, that she was able to tolerate "being with them" and was therefore able to demonstrate her great strength, which was her sense of humour and sociability so that some of them have now become her allies. She felt that the parents in the group had helped her to deal with this... "talking to other parents, who have experienced what I've experienced, has helped me... I've had a good week and I've been able to deal with K better... I can't say he's cured but I can handle him better".

As a practitioner nurse researcher, I felt as though it would have taken many individual therapeutic sessions to have achieved this change in the parents self esteem, her interaction with her child and her ability to deal with her immediate social networks. I also questioned whether such finely tuned support would have even been as accessible and acceptable in individual "counselling sessions". This incident also demonstrated the considerable skills that these parents had to develop in order to successfully negotiate neighbourhood harassment on difficult estates. Such skills can be frequently unrecognised or not acknowledged. However, it also seemed to highlight the need for support of these very isolated, vulnerable and often scapegoated

mothers if they were ever going to be able to express their skills and be able to stay calm when a child is highly aroused in order to manage the situation. Parenting groups seems to achieve this support very well. The parents actually said how “*good it was to trust others in the group with these kind of feelings*”. Parents were thus able to help service providers develop an insight into their needs and how to proactively respond to them.

Table Ten illustrates how the parents across the cohorts were able to both translate and utilise research literature, but that they rarely have access to it. Table Ten highlights how the parents experiences, knowledge and skills were helpful in refining professional knowledge by translating concepts such as temperament, information processing, resilience and developmental norms into the everyday language used in the parents’ context. Parents also highlighted that there may be a tendency (conscious or unconscious) for professionals to engage in a tacit hegemony of knowledge by not sharing the published literature with parents and children, despite the parents in this thesis unanimously finding these concepts useful.

Table Ten: Illustrating how parents translated concepts of temperament, information processing, resilience and social norms, how they related to them and how they felt they should be disseminated

<u>Concepts</u>	<u>Temperament</u>	<u>Information processing</u>	<u>Resilience</u>	<u>Social norms/ Developmental norms</u>
Number of parents who had heard of these or who used these in their everyday vocabulary prior to participating in the research (N = 25)	None	None	None	None
Ways in which parents related to these concepts/ translated them to their experiences	<p>"Born loud" – "shouts even when you're next to him"</p> <p>"Want own way no matter what and goes on and on about it"</p> <p>"Always sees the down side of everything"</p>	<p>"Doesn't seem to learn/take a telling", "does the same thing over and over again"</p> <p>"Can't think things through. Just does first thing that comes into his head"</p> <p>"You need to help some children to listen- others learn themselves"</p>	<p>Having the strength to cope after feeling you've gone back to square one: "you've got to be able to pick yourself up and think here we go again"</p> <p>Knowing that everybody needs to realise how much stress they can deal with before they need extra help</p>	<p>"You need to know that they may be very good at one thing but need help in others"</p> <p>"You have to be on the look out to see your bairn's keeping up and if not why not, but you need to understand that all bairns are different and need different things to help them do their best"</p> <p>"If you've ever thought that if your child isn't like all the others, they've had it and then think again- who's saying that?"</p>
Number of parents who could relate to the translation of these concepts and effectively apply them in their everyday experiences	All 25 of N=25	All 25 of N=25	All 25 of N=25	All 25 of N=25
Number of parents who felt knowledge on these concepts should be widely disseminated in schools, GP practices, etc.	All 25 of N=25	All 25 of N=25	All 25 of N=25	All 25 of N=25

Advice which parents wanted to give professionals was about working with parents whose children have behavioural difficulties, the following issues were echoed throughout all of the cohorts:

"Ask me how I feel because if I feel stressed, I can't do me best for me bairn" (Parent 2 cohort 3)

"Instead of jumping to conclusions, listen to all of the things that are going on" (Parent 1 cohort 4)

"Remember my bairn has a point of view too" (Parent 2 cohort 7)

"Don't tell me how well I'm doing when I tell you I need help ... telling me I'm doing well is just another way of saying "Go away". Listen to me!" (Parent 3 cohort 8)

The parents also identified that universal institutions such as schools need to adapt to the wide range of "normative" behaviours including the different temperamental profiles and social and cognitive needs that are representative of a "universal" population of children:

"Schools need to be there for all bairns" (Parent 2 cohort 1)

The parents identified the need for a wider dissemination of child and adolescent mental health education and understanding (including the implications of temperament, information processing, and development and how to promote resilience (in schools, education, GPs, social services, recreation and respite services:

"Divn't tell us - tell that lot out there- me doctor needs this... me bairns teacher needs this". (Parent 1 cohort 5)

The parents supported the need for a wider public health education on understanding child and adolescent mental health in order to change public attitudes/attribution about parents who have children with behavioural difficulties and thus to challenge

the tacit social belief that social penalties should be imposed on parents of a child, who does not conform to the “run of the mill” behaviour of children.

“We should all be on the telly - people should know about our bairns- they might more understand in the future”’. (Parent 2 cohort 6)

The parents identified that parents and children need to be consulted on what they need rather than be expected to accept what they get.

“I wish they'd listen to what I say - when I say I need help - I mean it”.
(Parent 2 cohort 4)

“I need to get some help - that doesn't mean sitting in a f--- office talking!”
(Parent 1 cohort 6)

All of the parents across the groups reported how much they valued getting feed back on how their role was helping/contributing to the research and to developing the professional insights:

“I feel dead chuffed to think I'm helping you and that it can help others in the future” (Parent 3 cohort 2)

“You're learning from us... and we're learning from you... that makes me feel good”
(Parent 1 cohort 7)

Strategies which parents advised were useful in helping to engage them were:

- The group facilitators explicitly acknowledging with the parents that the aim was to collaborate with them in order to engage in reciprocal learning - not to “teach them”.
- Taking time each week to allow parents to reflect on previous week and respect their need to offload their stress and to use this as a platform for exploration and discussion.

- Taking time to help parents feel cared for and nurtured within the group
- Sharing research/professional knowledge, asking for parents help to translate this knowledge into ways which are more accessible to group (see table 2 above) and then letting parents check this.
- Exploring actual, incidents, which are relevant and have critical meaning to the parents
- Acknowledging parents strengths, but not minimising their needs

Limitations to the transferability of proposition 4 identified by the parents

The parents demonstrated that they can potentially increase the systemic capacity to respond effectively to the needs of these children by helping professionals and service providers to develop a greater insight into the child and family's experiences and by highlighting the potential for practice change. However, a range of key findings emerged, which were consistent across the eight cohorts for the 25 parents which illustrated the social oppression experienced by these parents and children and which impacted negatively on their capacity to cope with these children. Through discussion and analysis of their experiences, parents helped to identify a range of tacit social assumptions/constructs, which gave rise to oppression of children with behavioural problems and their parents. These can be summarised as:

- In order for society and organisations to function, there must be collective norms and rules of behaviour to which children must be socialised. These social norms of behaviour for children are "natural" and generalisable to all children across contexts and cultures. Children unable to conform to these rules/norms are naughty or ill /abnormal.
- A parent's role is to socialise their children in accordance with the prevailing "social rules of behaviour". Parents who deviate from this are bad/subversive/ill or in need of medical help or social work support to cope with their child's behaviour.
- Social penalties should be imposed for both parents and children, who do not conform to the social "norms" of behaviour unless the child's behaviour can be sanctioned through a mental illness diagnosis or a special educational needs label.

- Schools and other institutions must act as agents of social control in reinforcing the rules and behaviours, which are attributed to be “natural and a given” rather than a social and cultural construct at a point in time.
- The recognition of “deviation” from the norms must be carefully controlled by specialist services and in order to access these services, parents and children must fulfil specified criteria, which are rigorously defined by professionals and policy makers.
- The experts must control the knowledge base, which underpins diagnosis/ recognition of deviation.

The parents across the cohorts illustrated a number of ways in which the above tacit assumptions impacted on their everyday lived experiences and these will now be illustrated and discussed in turn.

Parents reported a number of ways in which their children were marginalised:

“You're Ok as long as your child can do as they're told - but if they're a bit different or find it hard to sit for the right amount of time or do the same as the others, then they don't stand a chance-they get labelled as naughty and difficult and they start to get blamed for everything.....” (Parent 1 cohort 1)

“They won't let him be treated like an individual... differently ...I say...just leave him alone if he throws a wobbler... he needs some time and then he gets over it, but they say they can't let the other children see him getting away with his behaviour- I can't get through to them” (Parent 3 cohort 2)

“He always gets the blame - even if he isn't there!” (Parent 1 cohort 2)

“He needs help in the classroom, but they say he's not up enough levels for him to get special needs - I don't know what he does have to do - maybe burn the school down” (Parent 3 cohort 6)

All of the parents discussed their difficulties in coping with a growing sense of isolation, because they wished to avoid the sense of humiliation, when neighbours, friends and other family members could not accept their child's behaviour:

"My life stopped, when X was born.... I don't bother going to friends any more, because I'm too embarrassed and I can't bear dealing with his behaviour and how other people look at him and react to him" "I thought I was the only one going through this" (Parent 1 cohort 6)

"I try to go the supermarket late at night before the kids go to bed, so that if they play up, I don't have such a big audience" (Parent 3 cohort 2)

The parents discussed the marginalisation and social penalty which both they and their child endured as a result of not being a parent of a child or not being a child who conforms to the "norms" of behaviour. A recurrent theme which emerged in each of the eight cohorts was that of the "school gate syndrome" e.g.

"I dread going to the school gates ...wondering what the teacher will say to day. I feel so embarrassed in front of the other parents" (Parent 1 cohort 1)

Another was the ritual supermarket humiliation:

"I dread going to the shops...they have all the sweet toys lay out to attract the bairns. If you've got a child, who can't deal with not being able to have them. God help you... they look at you as if you're a really bad, useless parent" (Parent 2 cohort 3)

Parents described how they felt that there was a tacit social rule, which did not allow parents to express strong negative feelings about their children. Breaking this rule, made them feel inadequate and guilty yet maintaining the rule increased their sense of tension to such a degree that it sometime impacted on their own mental health. All parents revealed profound feelings of guilt, sadness and failure that they silently endured:

"You can't tell anyone..... I've thought of just driving into another car or taking a bottle of paracetemols. But I think, "Who would look after him then". (Parent 3 cohort 4)

"I've felt so desperate a times. As if I just can't go on and there's no one to turn to."
(Parent 2 cohort 7)

Three of the parents were clinically depressed and receiving treatment and a further eight parents admitted to having symptoms of depression such as difficulties sleeping, loss of appetite and feelings of hopelessness. All parents revealed the profound feelings of failure, guilt and sadness they endured

All 25 of the parents across the eight cohorts discussed experiences of being harassed in their neighbourhood, because their children's behaviour did not allow them to conform to either school or community standards. It seemed to be worse for single female parents on deprived estates. Parents described how they became scapegoats and described being threatened by men from the local community banging on their doors and aggressively demanding that they controlled their children. All parents across the cohorts reported experiences such as:

"I sit and wait for the knock at the door and the complaint about what he's done"
(Parent 3 cohort 1).

Parents felt that they had to cope with their deep sense of chronic powerlessness to get appropriate help in the system. This disempowerment led to feelings of pessimism and helplessness:

"I've been banging me head off a brick wall for years trying to get someone to see me bairn's got problems- they just think it's me" (Parent 1 cohort 2)

"I've really had to fight to get anything done." (Parent 2 cohort 1)

"The hardest part is when they you feel they won't accept your child has problems and they're just judging you" (Parent 3 cohort 3)

"I can't see anything changing" (Parent 2 cohort 5)

"I sit and worry about how he will turn out... which prison he will be in"

(Parent 2 cohort 6)

At the beginning of the groups, parents in each cohort articulated a range of ways in which they initially felt that they were disempowered by professionals they had been in contact with. These included difficulties of challenging the "experts", because they felt intimidated by their power and status. All of the parents, who had had contact with professionals because of their child/children's behaviours, described their sense of intimidation when confronted with a "powerful" professional or group of professionals:

"I feel they're all judging me" (Parent 1 cohort 2,)

"When you're with the doctors and psychologists, it's like you've got to go up to their level because they can't come down to ours" (Parent 3 cohort 6)

"It's like – you're the pupils – we're the experts" (Parent 2 cohort 4)

"I felt like I was a guinea pig" (Parent 3 cohort 4)

"You feel as though you've got to be on your best behaviour", (Parent 1 cohort 7)

"I was at a meeting at the (Child mental health unit – my emphasis) – I was terrified. They never asked me how I was feeling" (Parent 2 cohort 8)

"I feel as though they've just read books – they know that children can have tantrums but only mothers can really experience it, but I don't know how to explain what it's like". (Parent 3 cohort 6)

"I don't feel as though they're interested in what I've got to say ... yet I'm the mother" (Parent 3 cohort 4)

Parents felt that they had to deal with the verbal and non verbal barriers, which they perceived increased the power divide between parents and professionals

"When I went to (child and adolescent mental health put-patients) I felt as if they're looking down on me...they have that quiet voice and it makes me feel as if I'm dead rough" (Parent 3 cohort 2)

"That quiet voice you get as if you're made of glass ...it makes me cringe" (Parent 4 cohort 4)

"I know I'm dead rough but I can't stand being spoken to in that simpery tone as if they're afraid I'll gan off it" (Parent 1 cohort 5)

"They sit in a group and welcome you -they don't realise how awful it is going in to join that cohort- I just wanted to run away" (Parent 2 cohort 7)

"I don't understand half of what they say, but I daren't say anything in case they think I'm thick" (Parent 3 cohort 6)

The parents described how they felt that services were provided on the basis of what they want to offer rather than being responsive to the child/family's presenting needs. All 25 of the parents across the eight cohorts described how they felt that their needs were defined by the services without their consultation. Twelve of the parents described how they had asked social services for help but had been told that they were coping too well to merit additional resources. Other parents did not receive the help they wanted, but were offered what was available. This was illustrated particularly graphically by the following examples:

Critical Incident 9

"Eventually the social workers came out and I thought - thank God - we're getting somewhere. I wanted help with a break. I was at the end of me tether. On me own. Four kids and him like he is. I couldn't believe it - they measured me house up for a new bath. He's got slight spina bifida, but I can cope with that and so can he. He runs

around with the rest of them...I didn't want help with that. They couldn't help with any support with him, but I'm getting a new bath!" (Parent 4 cohort 4)

Critical Incident 10

"I wanted some help to cope with him and a break for me. I didn't feel I could go on. We went to family therapy, but didn't find it helpful and then they offered us this carers scheme, but I had to drive him 20 miles there and back for 2 hours - that was no break to me. I just had to wait in the car until he'd finished- it was exhausting" (Parent 2 cohort 5)

Critical Incident 11

"I got help for a while - I saw x at the specialist [CAMH] unit but then I was discharged because they felt I was doing OK at the time and now I'm here because the problems are really always with you" (Parent 2 cohort 6).

The parents increased the systemic capacity by providing professionals such as the group facilitators with increased insight into their experiences, strengths and needs and how to develop effective and individually and socially acceptable solutions (such as recreational activities for their children). The parents also added to the literature and evidence base on parenting programmes such as Cunningham et al 1995 and Webster-Stratton 1998, by reinforcing the basic programme content recommended in such research, as discussed in chapter 2, for example the importance of paying attention to their children and communicating positive aspects of their behaviour, setting limits and giving clear instructions, using 'when—then' phrase and ignoring difficult behaviour. However, the parents added to and refined this basic programme content by identifying that they also felt that they needed to have access to the underpinning principles of attachment and information processing in order to develop the insight and motivation to apply these principles in very challenging circumstances. It is significant that all of the parents found this information useful, but none had had access to it prior to engaging in the research. The parents were also able to critique and provide insight into the difficulties of applying the principles in programmes such as Cunningham et al 1995 and Webster- Stratton 1998 in challenging psychosocial conditions, for example how the behavioural principle of ignoring unacceptable behaviour is extremely difficult when the child is temperamentally persistent and the

parent is experiencing major psychosocial stressors. The parents thus seemed to acknowledge that there are important principles in traditional parenting programmes such as Cunningham et al 1995, but that these need to be augmented with more information such as the research related to temperament. In addition, they illustrated the importance of having access to research on risk and resilience and how developing confidence within a supportive group setting can increase their resilience through support to each other and also by reducing their sense of helplessness through challenging the status quo and advocating for their child and family.

Summary of findings

The findings from this study were based on the 25 parents, who acted as participant researchers in this thesis and who contributed to the data by virtue of participating in a complete action learning cycle. These were the parents who also attended 75% of the session including the first and last session. There was no significant difference in the socioeconomic variables between the 25 parents who attended and the other 50 parents (See Table 1 in Chapter 4). Thus all but one of the 25 parents, who became participant researchers, had substantial socioeconomic difficulties. The literature indicates that parents with these socioeconomic difficulties are traditionally much more difficult to reach and engage in parenting group work (See chapter 2).

However, these 25 parents not only engaged consistently in group work, but also in participative research and thus provided some in depth knowledge and critique about the reciprocal transfer of knowledge between professional contexts and challenging community contexts. The difference between the 25 parents who participated in the research and the other parents appeared to be in their ability to contribute to the first group session and their capacity and confidence to consistently attend a group venue. It was not possible, given the constraints of the research, to follow up the parents who did not engage. However, the 25 parents who did attend, provided a substantial amount of evidence on the level of guilt and oppression experienced by parents with challenging behaviours, which may indicate why the other parents found attendance difficult. However, further research is required to explore this further.

The 25 parents, who engaged as participant researchers found the skills and knowledge of the nurses (Croom 1996) and gaining access to a range of literature to be useful in helping them care for their behaviourally challenging children. The

socioeconomic variables were comparable between the 25 parents who attended and participated and the 75 of the initial population invited to participate. Prior to engaging in the research, the 25 parents had experienced great inequity in relation to being able to access relevant published information and to being participants in the knowledge creation process. This contributed to their difficulties in getting their voice heard, their experiences acknowledged and their needs met.

Although the 25 parents found sharing information from the nursing research useful, they also highlighted why and how this was limited by a range of macro and meso factors.

These included a tacit oppression of parents whose children do not conform to the behavioural norms as well as the impact of psychosocial stressors such as housing difficulties, mother blame and neighbourhood harassment. All of these stressors differentially impact on a family in a community setting as opposed to nurses in an institutional setting.

Parents described how they felt intimidated by professionals with “legitimated” qualifications and identified how a tacit idealisation of carers along with a simultaneous devaluing of the sophistication of care can serve to silence the debate on the socially constructed definitions of behavioural norms and to reinforce the hegemony of the professionals. The experiences of the parents in the study indicated that their children’s needs could be obscured by too narrow a definition of the behavioural norms, for example not acknowledging the wide distribution of temperamental traits in the population could lead to their child feeling marginalised. Furthermore, the family’s holistic needs e.g. for respite and recreation could be obscured by too narrow a focus on what services are funded to deliver rather than what families actually need.

The parents illustrated a number of ways in which their capacity could potentially be increased. These included providing them with the opportunity to access the literature on temperament and risks and resilience as well as having the opportunity to engage in research service with providers in order to help them to understand and adopt a total systems approach to the family’s needs. The parents highlighted that this requires a psychosocial response which takes into account the parents’ need for nurture,

respite, recreation and emotional, social and material support. The parents demonstrated a number of ways in which they could increase professional and service provider's capacity through helping them to acquire an increased insight into the families' everyday experiences and the multiple variables which impact on them. They were also able to provide advice on how the system needed to change in order to increase the capacity to respond to children with behavioural problems. This focused on working in partnership with parents to listen to them and to acknowledge and respond to their individual profile of needs and strengths with a menu of strategies, which are individually and culturally relevant to the child and family.

Table Ten summarises how parents are excluded from access to information, which they not only find helpful, but which they can translate effectively into their everyday context. This translation of complex research concepts into the language of everyday care represents one of the ways in which parents can refine and develop the knowledge and skill base for children with behavioural problems. Despite the expertise the parents demonstrated, the findings illustrated that like the nurses (Croom 1996); they felt relatively disempowered when confronted with professionals with "legitimated knowledge". However, access to research, participating in the research and being part of the group seemed to help them to recognise their collective strengths as carers and to begin to challenge the systems with which they and their children interacted and therefore to become greater advocates for their children. The implications of these findings for nursing knowledge in CAMH and for developing methodologies in nursing designed to produce knowledge for and about practice will be discussed in the remainder of this thesis.

Chapter Seven

Comparison of the published literature with the additional contributions to practice knowledge provided by the collaborative analysis with the parents of both their experiences and the solutions they proposed.

Introduction

The findings illustrated that parents were able to engage in the participatory action research approach to develop solutions to caring for their children with challenging behaviours. They were also able to successfully apply a range of technical knowledge such as that of temperament and information processing to enhance their insight into and care of their child with challenging behaviours. It was significant, however, that none of their parents, had previously had access to this literature prior to engagement in this research. Furthermore, the findings indicated that parents could not only apply this knowledge, but they could actively develop and refine published technical knowledge. For instance, the parents described how their children often found it difficult to gauge time and had no conception of 'how long' so found waiting difficult. On reflection, the parents identified that this was probably related to their child's difficulties with information processing. Making this link helped to develop further insight into how their child's information processing difficulties had a detrimental impact on their lives and so provided parents (as it had nurses in the previous study), with the insight to teach and support children with their concept of time and to break their day down into smaller and more manageable and meaningful chunks of information.

The analytic difficulties encountered in integrating diverse knowledge sources to inform practice is increasingly being recognised (Pawson et al 2004). In this thesis this integration was provoked by the critical analysis of the complexity of everyday care of children with behaviour problems. Technical knowledge which was found by the parents to be useful in understanding and then developing care for their children with challenging behaviours was abstracted and incorporated into the new practice framework (see Chapter Eight and Appendix Two). This included literature on:

- (1) Attachment because this helped parents to understand the significance of the child feeling in tune with their carer and vice versa. This is crucial in the development of emotional regulation that is essential to children in being able to manage their frustrations without resorting to challenging behaviours in which they may become a danger to themselves or others.
- (2) Temperament because this helped parents to develop insight into how to 'connect' or get in tune with their children. It also helped with reducing the parents' level of guilt and their attribution of blame of their children, by focusing on temperament as a set of inherited but modifiable traits.
- (3) Information processing because it helped parents to gain insight into the child's difficulties and then to teach their child the micro skills of processing information, which most children learn spontaneously.
- (4) Ambivalence in caring relationships, because it helped to normalise the complex set of feelings, which the children evoked in their parents.
- (5) Risk and resilience because it systematically helped parents to recognise their holistic set of child, family and community strengths and needs, to identify ways of responding to their strengths and needs and to advocate for the child

and family by optimising the total set of resources at an individual, family and community level.

Thus the findings chapter has identified a cumulative set of knowledge, which the parents found helpful in their everyday care of their child. This emerged from the parents inductive analysis of both the body of nursing knowledge and skills that was derived from a diverse range of sources, as discussed in chapter 5, as well as other published CAMH literature, which the parents found was helpful in responding to the critical incidents they raised. However, by engaging in critical analysis, the parents also identified that a major constraint of the nursing knowledge and skills and other CAMH literature was that they did not take into account the psychosocial variables, which impacted on their capacity to be able to apply this knowledge in the pursuit of health for their child and family, within their everyday context. Furthermore, the nursing and CAMH literature seemed to only suggest solutions at an individual/family level but did not explore or identify the psychosocial solutions, which parents proposed would be helpful in maximising their capacity to care. This chapter continues the iterative process of developing and refining a cumulative and emancipatory practice knowledge base, by locating the additional contributions which the parents made to the understanding and development of emancipatory practice knowledge for providing 24 hour care for children with disruptive behaviour problems, in the context of current literature. In order to achieve this, there will be an analysis of the key psychosocial factors, which the 25 actively participating parents identified affected their capacity to apply the nursing knowledge and additional CAMH knowledge and the key psycho-social solutions/interventions, which parents

suggested would make a significant difference in providing care for their child in their community context.

**Psychosocial factors which impacted on the capacity of parents to transfer/
generalise knowledge to their community context**

The parents identified the following factors which they felt directly impacted on their capacity to care and to apply the knowledge they accessed through the group to their everyday context.

- The guilt, blame and oppression experienced by parents of children with behavioural problems in this thesis.
- The simultaneous idealisation and devaluation of carers identified which served to maintain their oppression by emphasising that parenting is 'natural'. This belief that parenting is natural made it taboo for these parents to admit any parenting difficulties and also served to minimise or render invisible the set of sophisticated skills required for caring and the stress it engenders, especially under adverse conditions, such as the socioeconomic difficulties experienced by 24 out of 25 of the parents actively participating in this thesis.
- The lack of recognition of the parents own need for nurture, which they identified played a significant role in undermining their confidence, oppressing them and reducing their capacity to respond effectively to their child.

The key solutions, which the parents identified, were:

- The need for CAMH services to take a systems approach in order to respond to their child and family's holistic set of needs.
- The need for additional practical support including recreation and respite and
- The need for continuity of care and support rather than episodic care for children with challenging behaviours.

Comparison of literature with the guilt and blame experienced by parents of children with behavioural problems in this thesis.

At the start of each cohort parents reported that they felt overwhelming guilt and experienced feelings of blame and social penalties, for having a child who did not conform to behavioural norms. They felt this was augmented by a tacit social rule demanding a culture of silence on any parental experiences, that challenged the “parenting ideal”, which they felt as parents they had been socialised to achieve and which they felt was propagated by and reinforced in the media. This culture of silence on any critique of the parenting norms has been identified in a range of sociological and feminist literature (Ruddick 1989, 1994; Swigart 1991). However, a search of CAMH literature highlighted that there was a dearth of literature, which acknowledged or critically explored the theme of mother blame or which engaged in critique of CAMH from a sociological or feminist perspective. Nevertheless, there were some earlier examples of CAMH literature, which analysed mother blame. Caplan and Hall-McCorquodale (1985) reviewed the literature related to parenting in the years 1970, 1976 and 1982 to determine whether any reduction in “mother blaming” had occurred as a result of the women's movement. They found that very few changes in the attributions of mother blaming had occurred across the target years

and that mother blaming was only slightly affected by the type of journal and sex of author. Chess and Thomas (1982, p.24) investigated “bonding” literature and concluded that health professionals have legitimised the tendency of lay people and professionals to blame mothers for whatever goes wrong with their offspring. They argued that this was epitomised by Bowlby’s (1951) work on “maternal deprivation” and acknowledged that whilst “such reports had an influence in highlighting the psychological needs of the young child and on emphasising the importance of a human nurturing environment for the infants healthy development” that “such considerations are different from the ideology which crystallised in the 1950’s in which the causation of all psychopathology from simple behaviour to juvenile delinquency was laid at the doorstep of the mother...” (Chess and Thomas 1982, p.218). Chess and Thomas (1982, p. 220) argued that “the guilt and anxiety created in those mothers whose children had even minor deviations were enormous”.

Whilst later CAMH research such as Rutter and Rutter(1992) and Clarke and Clarke (2000) emphasise the importance of a range of care giving relationships and the role of attachment across the life span and not just the contribution of mothers, the parents participating in this thesis described how their experiences of mother blame was associated with their own belief system, which they unanimously felt was socially reinforced, that the mother should be ascribed the main caring role, (particularly in the early years) and thus be ascribed the blame for their child's behaviour problems. The tendency of society to tacitly reinforce mother blame and the difficulties this created for mothers to then challenge this has been extensively explored in social science and feminist literature for example, Maushart (1999) explores the theme of mother blame and the difficulties mothers have in actually acknowledging or discussing it.

All of the parents in this thesis were mothers and only one had a partner. At the beginning of the group sessions, all of the mothers were seeking out reasons for where they personally had gone wrong with their child and yet they did not initially explore the role of the father or other caregivers in the parenting process. The aim of this thesis is not to add to the social science/feminist literature on mother blame, but to analyse the implications of these tacit assumptions on providing 24 hour care to children with challenging behaviours and the implications for CAMH practice and service delivery. This is discussed further in chapter 8.

An analysis of the evidence base on parenting programmes in CAMH literature also seems to suggest a parent blaming approach. Herbert (1994, p.870) describes how professional sources and agencies have looked to “training parents in group settings to meet the shortfall in professional resources for children with challenging behaviours”. The training involves “reducing confrontation, and antagonistic interactions among family members, increasing the effectiveness of positive interactions and to moderating the intensity of parental punishment”. Herbert (1994, p. 870) describes how the rationale for this “comes from research, indicating that parents of aggressive, anti-social children often lack basic parenting skills. They frequently engage in coercive commands and criticisms with high rates of threat, anger, and nagging and negative consequences”. This perspective is supported by many examples of contemporary CAMH literature which informs professionals on the management of child behaviour problems (Kazdin 1995, p.82, Webster-Stratton 1998, p. 717). These were discussed in detail in the Literature Review given in Chapter Two. Herbert (1994, p. 870) identifies the 5 components of the Oregon Social Learning Centre, which he argues has provided the seminal influence internationally on parent training:

- (1) Parents are taught how to pinpoint the problematic activities and track them at home (e.g. compliance v. non-compliance)
- (2) They are taught reinforcement techniques (e.g. point's systems/praise) and disciplinary methods
- (3) They learn "response cost" i.e. when parents see their children engaged in inappropriate behaviour they apply a mild consequence such as time out or a short term deprivation of privileges.
- (4) They are taught to monitor or supervise children even when they are not at home, so that they know where their children are, what they are doing and when they will return.
- (5) They are taught problem solving and negotiating strategies so that they become increasingly responsible for designating their own programmes.

The emphasis is thus very much on 'teaching' the parents. Key researchers in this field such as Cunningham (Cunningham et al 1995) and Webster-Stratton (Webster-Stratton 1998), themselves trained at the Oregon Social Learning Centre and have thus integrated these key principle into their work. Herbert (1994, p.870) also discusses how "the therapist must be skilled in coping with the parents' resistance to change that characterises the majority of families referred for treatment" and he argues that this requires a high level of therapeutic skill on the part of the professional. Herbert's approach thus appears to attribute much of the blame for significant behaviour problems to parents whilst simultaneously reinforcing the power and expertise of the professional to provide the remedies/treatment. The current emphasis on the use of standardised manuals for parenting programmes (Cunningham et al 1995, Webster-Stratton 1998) can serve to perpetuate this position. As the aim of the manuals, written by 'experts' and located in the CAMH evidence base are

generalisable, they do not incorporate a critique of the content or underpinning assumptions by the parents and thus any tacit assumptions of parenting blame remain unaddressed. Furthermore the additional contribution to cumulative knowledge and skills that can be achieved through an analysis of the parents' own experiences, as illustrated in this thesis is not acknowledged in the positivistic evidence base on parenting programmes.

Despite the lack of acknowledgement of mother blame in CAMH literature, mother blame is not a new phenomenon in sociological and feminist literature. In western society, children's care and well-being is constructed as being inextricably linked to the conduct of mothers (Caplan 1998; Hays 1996; Ladd Taylor and Umansky 1998). Feminist authors (Jacob 1990; Presser 1995) have explored the oppression of women in families and Thorne (1993) has struggled with how to recognise the important contribution that mothers make, without falling into the trap of individualism (which this thesis indicates is exemplified in some of the CAMH literature).

The sociological and feminist literature and the CAMH findings of Chess and Thomas (1982) and Caplan and Hall- McCorquodale (1985) and the tacit assumptions underpinning the philosophy of the literature on parental training programmes seem to make sense of and support the guilt, social penalties and the overarching theme of oppression experienced by the 25 participating parents in this thesis, who were seeking CAMH help. Furthermore, parents highlighted the intervening variables, such as poor housing, low income and harassment, which can impact on their capacity to be emotionally and physically available to their children and also their capacity to follow the 'manualised' programmes advocated in the CAMH evidence base, without

significantly increased psychosocial support. This thesis indicates that these psychosocial and socioeconomic variables can limit the generalisability of the evidence base on parenting programmes and other CAMH literature to vulnerable mothers. However, the aim of this thesis is not to add to the body of sociological or feminist literature on mother blame, but rather to acknowledge it, explore the practice impact of it and in keeping with the philosophy of critical theory to challenge it and in keeping with the values of practitioner research, to avoid any tacit mother blame in this thesis. The thesis is not claiming that individual mothers do not affect their children negatively or that all mothering is desirable and acknowledges that the CAMH literature can be useful. Indeed, all of the parents readily admitted that the nursing information and information from the parenting programmes was helpful to them in changing their interactions and attributes about their child's behaviour. However, they illustrated that they also had knowledge to contribute to CAMH by highlighting that failure to take into account their psychosocial circumstances can serve to perpetuate mother blame (and thus reduce their capacity) for example through explanations that these parents are "hard to reach" and "resistant to treatment" (Cunningham et al 1995). These individualistic explanations can also serve to maintain the status quo of the service delivery in which the treatment regimes remains the same, but the parents are expected to change their attitude and motivation in order to engage with what services offer. Mother blame can also render invisible the strengths and commitment of parents caring for children who exhibit challenging behaviours. Despite their additional psychosocial stressors, the findings highlighted that the 25 participating parents exhibited a high level of concern for their child's welfare and could display resilience, competence and skill in frequently adverse circumstances.

The findings thus highlight the need to critically analyse CAMH literature and evidence base and challenge inherently oppressive assumptions that can lead to mother blame. Opening CAMH to feminist and social science critique can facilitate this critique. However, this requires change at a wider social as well as at an individual level. For example, current social policy such as the National Service Framework (DfES and DoH 2004) does not acknowledge or incorporate these critical professional debates on power and oppression despite advocating the philosophy of patient empowerment, user involvement and the development of a patient led service. If CAMH does not acknowledge mother blame, then it fails to acknowledge that mother blame puts a tremendous burden of guilt and anxiety on women and children and deflects attention from social solutions or ensuring the well being of children (Caplan 1998; Thurer 1993)

Comparison of the literature with the parents' experiences on the simultaneous idealisation and devaluation of carers

The parents' oppression appeared to be further perpetuated through an apparent contradiction, in which they experienced a tacit idealisation of carers that they perceived was projected through professional practice and the media. CAMh literature on attachment assumes that there is a biological preparedness of mothers and infants to engage in an attachment relationship (Brazelton and Cramer 1990, Sroufe 1996) However, social science and feminist literature have discussed how taking a biological approach can serve to render invisible the intensity of emotional and physical dedication and the sophisticated set of knowledge and skills (Swigart

1991, Maushart 1999). These sophisticated skills are required to sustain the physical and emotional care of children, whose challenging behaviours make additional demands on mothers living in depleted social and emotional circumstances. Whilst this idealisation and devaluation of the care process is well recognised in social science literature such as that of Ruddick (1989, 1994), it is much less debated in CAMH literature.

Paradoxically, the devaluation of mothers is analysed in some depth in the currently controversial area of Munchausen's by Proxy literature such as that by Schreier and Libow (1993, p.108). They acknowledged the "unreasonable demands" placed on mothers in our society... "While nurturing a baby has many rewarding aspects, it does little to address many women's continuing needs for a sense of self esteem and a sense of recognition and power as an autonomous person this may be particularly distressing to a mother who has experienced trauma or neglect as a young girl. When attention is lavished on the child at the expense of the child's mother and this situation is coupled with the child's enormous demands on the mother, we should not be surprised that many women are at times ambivalent about this all consuming job and the child making these demands" (Schreier and Libow 1993:108). It is not the intention of this thesis to debate Munchausen's by proxy syndrome per se, but to use this literature and the experiential evidence of the parents to highlight the extreme stress placed on carers. This can increase a general understanding and insight within CAMH of the need to provide psychosocial support to carers, who care for children with a range of CAMH issues.

Schreier and Libow (1993, p.109) also discuss how “motherhood highlights a woman's experience of finding her own needs increasingly submerged by the pressing needs of another. Her role as caregiver to others is in fact a lifelong expectation as that of nurturer.... they are likely to find themselves accepting this role later in life, though it may be with ambivalence and a host of their own remaining unmet needs”.

This links in with the finding in this thesis, which identified that the parents experienced a tacit social rule concerning the culture of silence on feelings of ambivalence or the sheer demand of physical hard work of motherhood, whilst they felt that the ideal image of motherhood and the bonding process is extolled in the popular press. The psychological costs of motherhood are dealt with in the literature of feminist social analysts such as Woollett and Phoenix et al (1991, p.36), who discuss how “work on maternal sensitivity rarely considers individual differences in mother's sensitivity and even less what the costs of the sensitivity might be for mothers”. The parents from this study and the evidence base indicate that these “costs” are not yet universally acknowledged in mainstream CAMH literature and practice and crucially are not acknowledged in current policy documents such as the National Service Framework for Children, Young people and Maternity services (DoH and DfES 2004)

Critical analysis of the parents' findings that carers need to be nurtured in order to nurture and be emotionally available to their children in the context of the wider literature.

The parents in this study (all mothers) described how they felt that they had great difficulties in being able to express and attempt to fulfil their own needs and actually seemed to have to learn to do this through the research group experience, where they felt they were supported and given permission to articulate their own needs. This was poignantly illustrated by the mother, who found that buying herself a pair of 99p socks felt a significant step forward in acknowledging and responding to her own needs. The parents' experiences indicated that the philosophy and social accountability to take care of the carers did not seem to be operationalised in service provision, despite the wealth of social science and feminist literature, which was found to support the need for this (Procter 2000; Ruddick 1989 and 1994; Swigart 1991). Again, there was limited CAMH literature, which analysed these issues, although Schreier and Libow (1993, p.110) discussed that "while many mothers do find socially sanctioned avenues for their competitive and assertive feelings, and either challenge traditional expectations or find indirect means for satisfying their needs for achievement, power, nurturance, they face obstacles on many levels..... Brought up from girlhood to value attachments to others, learning to please those around her, and to suppress her own anger and needs for autonomy, a traditionally socialised young woman does not grow up to feel well equipped or entitled to express her needs and make demands for herself directly.... and would be hard pressed to find means of expressing their discontent.... such a woman may feel immobilised to actively protest her dilemmas but she might also be quite emotionally needy for attention and care giving herself". Winnicott (1986, p.124) theorised that "Children grow up and become in turn fathers and mothers, but, on the whole, they do not grow up and acknowledge just what their mothers did for them at the start". This thesis

illustrates some of the empirical consequences of this and the implications for CAMH services.

Despite the considerable literature available on the demands of motherhood and the extra demands on carers with children who have behavioural problems (Cunningham et al 1995), the experiences of the parents in this thesis illustrated that there does not appear to be a sufficient acknowledgement of, or a response to this literature in CAMH service provision. The findings of the parents in this study thus seem to provide some empirical evidence on the impact of caring for children with challenging behaviours in their 24 hour community contact. This indicates that a crucial step forward in the management of children with behaviour problems is acknowledging the demands of care giving and the additional effort and expertise which carers require when a child has behavioural problems. Furthermore, this needs to be raised in the public, professional and policy consciousness in order to both challenge the oppression faced by parents such as those in this thesis and also to improve the effectiveness of CAMH services through providing the holistic, patient centred response, advocated by policy documents such as the National Service Framework for Children, Young People and Maternity Services (DoH and DfES 2004).

Comparison of the wider literature with the psychosocial solutions and responses, which the parents identified, would make a difference in their everyday lives.

1. Need for CAMH services to take a systems approach

The parents in this study recognised that although some of the technical literature was helpful to them, there were limitations to the generalisability of the literature to their everyday context. These findings are compatible with emerging CAMH research which identifies that “the efficacy of child psychotherapy observed in research settings has rarely transferred to effectiveness when delivered in community settings” (Weisz et al 1995).

Parents identified that achieving effectiveness in their context required a combination of both experiential and evidence based perspectives and individual, family and community solutions. Parents identified the need to take a wider systems approach in which there is a holistic response to the particular child and parents’ needs rather than a response which is defined by the professionals and circumscribed by what the service providers decide to offer. The parents thus seem to have an insight into the need to develop services and knowledge and skills via research, which has ecological validity in the context of their everyday experiences. The need to develop ecologically sound research is highlighted by Henggeler et al (1995) who identifies that there is a practice gap in how to develop research which demonstrates “effectiveness” in everyday practice rather than “efficacy” under experimentally controlled conditions.

In this study, the parents appeared to have an intuitive grasp of the need to understand their everyday lives as part of a total system. Although they were able to acknowledge the benefit of accessing knowledge on a diverse range of literature such as attachment, information processing and temperament, they were also able to and

environmental factors and the existing risks and strengths of the various systems (individual, peer, family and environment). Every effort is made to access resources in the family's natural ecology and to understand the fit between the various systems and the identified problems by emphasising family empowerment, mobilising indigenous community resources and using the young persons' and family strengths as levers for change. This means working with the families and their extant systems in order to cope with issues that impact on their ability to function (Henggeler et al 1994 and 1995).

The parents in this thesis discussed how they felt that it is crucial to work with an understanding of their child and family's specific needs and strengths, rather than responding to a narrow definition and deviation from norms, which leads to a "one service fits all" mentality. Multi-systemic therapy also takes into account the need to provide a supportive milieu, which the parents in this thesis identified was a critical factor in their capacity to care for their children. Henggeler et al (1995, p.716) argue that "When treatment proceeds as planned, the ultimate multi-systemic goal is to empower families to build ecologies that promote health. Parents will both nurture and guide their children. Children will have pro-social friends and behave responsibly at home. Families will be connected with mutually supportive social networks.

Although such an ideal may be met in only a small number of cases, even minimal movement towards these goals can improve the lives of families and their communities".

Multi-systemic therapy (Henggeler et al 1995) thus represents an evidence-based way of operationalising some of the wider systemic based solutions proposed by the

parents in this study. Despite the extensive evidence base of multi-systemic therapy in the CAMH literature, the CAMH services offered to children and families throughout the duration of this study were still focused on clinic based appointments. However, Henggeler et al (1997) identified that there were barriers to implementing multi-systemic therapy and these included the need for extra supervision of workers involved in 24 hour care, the need and ability to negotiate extra community resources, the lack of collaboration of extant systems such as schools, social care and health care providers and also the need to constantly modify clinical procedures in order to accommodate individual circumstances, which can be considered “to be a significant threat to internal validity in university based research studies by giving priority to “issues of practicality and external validity” (Henggeler et al 1997, p.820).

Henggeler et al’s (1997) findings thus appear to support the parents findings that there is a need to take a more innovative approach to service delivery and research if the outcome is to be effectiveness in practice as opposed to efficacy in experimental conditions, but he also cautions that there are both philosophic and resource issues to be considered in developing this paradigm shift.

Through their understanding of the significance of social norms, the parents in this study appeared to demonstrate their tacit understanding of soft systems thinking that “Social rules lead to social practice in which people live and learn together. Lying behind social practice is constitutive meaning... *(this) ... contributes meaning to social practice.* To get to grips with the whole therefore involves the construction of understanding in terms of constitutive meaning, social practices and actions taken.” (Flood 2001, p.138). The parents initially appeared to have internalised and accepted the tacit social assumptions/ ‘constitutive meaning’, *which* condoned the blame and

oppression of parents by those with “legitimated knowledge”, but as the group progressed, they were able to apply the principles of participative action research and critical theory to critique this position and to use this to transform their understanding to a social meaning which emphasised their rights as parents to be supported by the system. They were able to build on this to change the constitutive meaning used by others in the system by challenging their interpretation of their child’s behaviour (for example some parents were able to negotiate different meanings and interpretations of their child’s behaviour with their child's teacher).

The parents discussed their experiences, which indicated a gap between what services offer and what children and families actually need. Weisz and Weiss (1992), Henggeler et al (1994) and Henggeler (1995) all acknowledge the gap between research and practice and emphasise “the need to bridge the gap between research and clinical practice and soon” (Henggeler et al 1995, p.710). Despite discussing the importance of empowering the family as discussed in relation to MST above, Henggeler et al (1995) do not acknowledge the role of families and parents as joint researchers, but continue to emphasise the superior validity of evidence produced using randomised control trials carried out by professionals, albeit in real clinical settings. This perpetuates the use of the dominant research paradigm to create knowledge in CAMH through statistical analysis and not through theorisation designed to change the constitutive meaning within the system. The findings from this thesis provides support for MST as a major improvement on the current configuration of services in the UK, but suggests it might be more powerful if the research methods used in developing MST included theorisation designed to change the constitutive meaning used by the different parties involved. The parents’ experiences appear to

indicate that in order to develop skills and knowledge for 24 hour care central to MST, a range of theoretical perspectives are required, which incorporates not only a systemic approach, but also an emancipatory approach, in which parents are not just the subjects of research, but are the creators of research.

2. The need for additional practical support including recreation and respite

Parents in this thesis identified a range of practical strategies, which they felt would be effective in responding to the needs of their child but which they currently had difficulty accessing. These will be discussed in the context of the current evidence base.

- **The need for the provision of recreation as a critical therapeutic tool for children with behaviour problems.**

Several examples have been given in this study which illustrates the parents' experiences of the therapeutic benefits of recreation for their children (see critical incidents 7 and 8 in Findings chapter). Although the parents described the extreme difficulties they experienced in accessing recreational services, there is a growing body of CAMH literature to support the parents' proposition that recreation for their children is an effective therapeutic intervention.

McKay et al (1996) have demonstrated that for any youth living in situations of increased risk (such as conditions of poverty) providing recreational activities is associated with healthier lifestyles, increased self esteem, desirable peer interactions and improved cognitive functioning. Browne et al. (1999) demonstrated that proactively providing subsidised recreation, enabled youth with an initial behaviour

disorder to achieve a level of health and competence similar to a mainstream population over a period of two years. Recreation was also found to be a cost effective strategy if the total cost benefit was calculated across the total set of services in the system (Browne et al 1999). Thus the evidence from parents found in this study on the positive impact of recreation on the everyday experience of children with challenging behaviour resonates with the evidence base on the therapeutic and cost effectiveness of recreation. However, the findings of this thesis indicated that it was more difficult for the parents to access recreation for their children than it was to receive therapy from a specialist service. The identification of an evidence-based literature which substantiates the recreational solutions identified by the parents as consumers, poses a question about why the evidence base on recreation was not currently operationalised for the parents in this thesis. Furthermore, as the findings from the parents in this thesis illustrated that significant therapeutic progress could be obtained through recreation, further research could be done in the to explore the cost and therapeutic benefits of recreation for children with challenging behaviours in wider studies in the UK

- **The provision of Respite Care**

All of the parents across the cohorts felt that they needed some kind of respite care in order to get a break and thus stay emotionally available to their children. However, parents unanimously found that respite care was the most difficult service to access. Nevertheless, there is a range of evidence which supports the therapeutic benefits of providing respite care. Doherty (1991), Zoritch et al (1998) identified the crucial role of providing respite and Browne et al (1999) found that proactively providing subsidised child care significantly reduced parental stress and was also cost effective

if the total cost benefit across all systems including health, education, social security and welfare were calculated. The resonance between the parents' experiences and the evidence base again poses the question on why respite was not being offered to them.

In multi-systemic work such as Henggeler et al (1995) discussed above, both respite care for parents and recreation are incorporated into the package of care. However, neither of these approaches was available to the parents, who participated in this thesis. The next chapter will attempt to theorise why this may be the case.

3. Provision for continuity of care rather than episodic care

The 25 participating parents expressed that they wanted to access services when they needed them. However, they felt that they received episodic support according to the needs and functioning of the services, rather than to their own fluctuating needs and this left them feeling that they had to "*bang their heads off a brick wall*" to obtain a response.

The strategy of providing services to children with disruptive behaviour problems on a flexible/responsive basis is supported by Kazdin (1995, p. 139) who proposes that "research on conduct disorder suggests that it is very much like a chronic condition in terms of its development and course The dysfunction has broad impact both during childhood and adolescence in affecting behaviour in home and at school, interpersonal, and cognitive spheres. It might be heuristically valuable to consider conduct disorder as a chronic condition that requires intervention, continuous monitoring and evaluation over the course of one's life". In one model, Kazdin (1995, p.141) suggests treatment could be provided pro re nata (PRN- as required) based on

assessment data or on emergent issues raised by the family, teachers or others. Kazdin (1995, p. 141) likened this kind of approach to the management of diabetes. He discussed another model, which has been successful in treating depression (Kupfer et al 1992) of using “maintenance therapy” or “doses” on a less intensive basis.

Parents highlighted that the balance of their strengths and needs in caring for their child fluctuated and that they thus required services, which could dynamically respond to the balance of their strengths and needs over time. The research literature thus seems to support the parents’ proposals for a responsive/flexible service, which can proactively respond according to the changing balance of needs and strengths of the child and family over time and yet again poses the question of why this was not available to the parents.

The research of Rae Grant (1994) has indicated the need to move to a service model in CAMH which promotes strengths and resilience at an individual, family and community level as a way of reducing individual and family risk. However, the parents in this study had not experienced this kind of flexible response to their needs and so felt that they had reach a crisis before they could access the service they required.

Summary

The findings from the parents in this study indicate that although the parents’ knowledge, experiences and solutions were significantly supported by a body of evidence based literature, the parents reported that this evidence base was not comprehensively applied or integrated into any service provision, which they

accessed. This thesis therefore indicates that CAMH service provision, as experienced by parents who participated in this thesis, was lead by experts and policy makers with “legitimated knowledge”, who only partially operationalised the evidence base. The parents do not seem to be suggesting that traditional CAMH research should be ignored as they found information derived from traditional research such as temperament and information processing very helpful. However, they were suggesting that services need to incorporate and apply a wider range of theoretical perspectives into CAMH literature and practice/service provision (including the families' experiential perspective and the social science perspectives on caring) in order to respond effectively to the reality of 24 hour parenting care and to develop the holistic insight knowledge and skills, which can maximise the total knowledge and skills (including that of the parents) in the total system. Without this broader perspective, there is a danger of services falling into the trap described by Flood (2001, p. 142) who discusses how “science through reductionism has in our minds fragmented the world, our existence and how we manage ourselves. Living is deflated to a mental model with ... an unrealistic simplicity of A caused B. This alienates so called parts, for example you and me, from patterns and rhythms of life in which we participate... it separates the problems from the complex dynamic of each unique context.... People are blamed in this way and are then found guilty in the kangaroo court of reductionism”.

The parents in this study all came from deprived areas but the close convergence between their experiences and findings in the literature appears to demonstrate how important it is for all parties (professionals, parents and children) to reciprocally share their information, knowledge and skills on order to develop a responsive service,

which is useful and relevant to the users. This is particularly important in the population chosen for this thesis because research indicates that they are less likely to access services and be included in research studies, therefore there is less research into what works for this group of people. There is very little evidence in the CAMH literature about what this excluded group actually finds useful in their 24 hour context and what professionals can learn from their experiences as opposed to experimental research. For instance, neighbourhood harassment, arising from their child's behaviour, which was experienced by most of the parents in this study is not widely reported upon in the CAMH literature, but provides a crucial context for professionals working with these families.

Although poverty is related to numerous disadvantages for children (Offord 1991) the convergence between the parents in this study and the wider literature on blame and guilt also tends to suggest that the findings and implications of these findings for the parents in this study may be relevant to a wider population of families. Parental blame which was identified as widespread in the evidenced-based literature by the work of Chess and Thomas (1982) and Herbert (1994) did not exclusively focus on deprived parents. It could be argued that more affluent parents could have greater access to recreation and respite care because they can pay for them. However, the sense of exclusion experienced by children and parents in this study arising from the child's behaviour problems, can also apply to more affluent children with behaviour problems and their families, who may find that access to recreational services is financially accessible but rejecting of their children when they exhibit challenging behaviours. Offord et al (1992) found that the greatest predictors of behaviour problems were family dysfunction and getting along with others. Both of these

factors could equally apply to more affluent families. Although Offord (1992) argues that eradicating poverty would not eradicate child mental health problems because they are widely distributed in the population, low income is recognised as an additional risk factor to developing behaviour problems (Meltzer et al 2000, Rae Grant et al. 1989, Offord et al 1992, Offord 1996).

The parents in this study all reported that managing a challenging temperament, difficulties with information processing and tuning into their children were exacerbated by concerns about money and housing. The research on risk (Rae-Grant et al 1989, Rae-Grant 1994) identifies that it is not single risks, but cumulative risks that predict the onset and persistence of child and adolescent mental health problems. A challenging temperament which leads to a mismatch with the parents' expectations, difficulties with problem solving and maternal depression, which can have an impact on attachment all have a wide distribution in the population (Chess and Thomas, 1992, 1996). The impact will thus depend on whether these risks simultaneously present with other risks in the presence or absence of protective factors such as warmth and support in the family and adequate parental breaks from the children which can protect against the risk of problems, even in situations of adversity (Rae Grant et al 1989, Rae Grant 1994). There appears to be a high likelihood that the information, which the parents in this study found useful on attachment, information processing and temperament, would be useful across a wider population of parents. The solutions which the parents in this study proposed such as the need to take a systems approach would also be likely to be applicable to a wider population of parents because this approach focuses on responding to the child and family's individual profile of risk and protective factors. More research is required to further

explore the generalisation of the findings in this study and how they could be modified or refined though exploring the experiences with a wider population of parents, including more affluent parents.

The experiences in this study and the literature have all focused on the experiences of mothers. Feminist literature such as that of Fineman (1995) suggests that using the term “parenting” as opposed to “mothering” obscures the social reality that admonishments to parents are in fact castigations of motherhood and adds to the oppression of a group in a gender stratified society. It is acknowledged in this thesis that feminist thought delineates and critiques the material and ideological systems of gender stratification and in doing so reminds us to be sensitive to the power relations and differences within situations and relationships and to question the conventional terms of analysis. This chapter has discussed the potential for mother blame in CAMH and identified the need to challenge it. The thesis uses critical theory to interrogate the power relationships. Further research into the role of gender in CAMH through a feminist perspective will prove illuminating in exploring these issues further, but is outwith the remit of this thesis. In addition, a further area of research could explore what fathers find useful and relevant when parenting their children with behaviour problems. Finally, there is increasing recognition in the literature on both CAMH and on the management of long term or chronic conditions for services to become more responsive to individual need and a growing body of evidence that doing this improves outcomes for service users (Wagner et.al 2002). However, it is important when operationalising these systems to pay attention to the needs of paid carers (Procter 2000) It is important that in developing these models the flexibility and responsiveness isn’t introduced at the expense of care workers. UK systems are highly

resistant to flexible responsive provision. This resistance has to be understood and theorised at an appropriate level if the problem is not to be transferred from the unpaid carers to the low paid carers. Much more detailed future work is required to address how to introduce flexible responsive systems which improve the lives of both unpaid and low paid carers.

A critical analysis of the parents' experiences in the context of current literature has thus demonstrated that participative work with parents can serve to identify and facilitate a synthesis of previously unlinked CAMH literature from psychological, psychiatric with wider social science literature in a way that can begin to explain the parents' oppressive experiences and to support their solutions. Furthermore developing the parents' role as participant researchers, in which they identified the psychosocial determinants of health that prevented them from achieving their health potential, appeared to support them to challenge the dominant CAMH ideology and literature, which seem to take an individualistic and intra-psyche approach as opposed to a social approach. The next chapter will attempt to build on this and to explain and theorise why neither the individualised CAMH literature such as that on information processing, nor the social approach to CAMH had previously been shared with the parents, despite the findings that parents found both approaches helpful in developing their capacity to understand and meet the needs of their children.

Chapter Eight

Theoretical Model emerging from analysis of findings

Introduction

This chapter reviews the literature on CAMH service provision using a critical theory approach in order to develop an explanatory theory, which is grounded in the findings of this thesis, as to why the evidence in CAMH appears to have been only partially and selectively implemented for the 25 participating parents in this thesis and why knowledge and skills that could have helped the parents to cope and care for their children with challenging behaviours were not disseminated to them. In order to develop this explanation, the chapter analyses the data in the context of the medical and social models of health and proposes that the experiences of the parents reported in this thesis can in part be explained by the domination of CAMH provision by the medical model. It theorises the individualistic approach which characterises this model and uses this theorisation to explain how the domination of provision by the medical model can restrain service development, and despite the best efforts of practitioners, may prevent them from providing the optimum service for this client group. The chapter uses the application of critical theory (Fontana 2004; Khanlou and Peter 2005) in order to question the domination of knowledge and ideology in CAMH by the medical model and to reveal how the dominant forms of knowledge are used to support this particular approach to service delivery.

This analysis thus attempts to explain why there is a need to incorporate a social model of health into CAMH practice based on the experiential evidence from the parents and the parents identifying the critical importance of psychosocial support in

enabling them to provide care for their children. The parents at the beginning of this research appeared to be oppressed by a professional hegemony of knowledge in which they did not recognise their own oppression or that of their children. It is suggested that this could arise from a lack of parental access to knowledge and its creation. The findings indicate that access to knowledge, its creation and critique as participant researchers can be an emancipatory process for the parents. This can enable parents to articulate their tacit sources of oppression and through critiquing these, to take charge of their own lives and those of their children and also to recognise the structural changes that are required to create emancipatory changes in service provision. However, the parents in this thesis indicated that access to knowledge was useful, but not sufficient to produce practice change and development. This chapter discusses the need to synthesise a medical, social and emancipatory approach, when engaged in participative practice research with parents to produce practice change and to develop practice theory and knowledge related to the 24 hour care of children with challenging behaviours.

The theoretical discussion, developed in this chapter, also explores whether in a context where CAMH needs outweigh resources, active collaboration with parents (who carry out the bulk of care in the community) through reciprocal knowledge dissemination and joint identification and response to needs, could potentially increase the total systemic capacity to respond to these children with challenging behaviours. In order to develop the theoretical analysis of the findings, the chapter draws on the principles of critical action research (Fontana 2004, Thomas 1993) used in the collection of data to look at 'what could be' and not 'what is' (Thomas 1993, p:4) if parents are actively involved in the critique of knowledge and the creation of

knowledge and how this can impact on the systemic capacity to care for children. The chapter concludes with a description of a practice framework (Appendix 2) that synthesises the findings of an inductive analysis of the nursing framework (described in chapter five) by parents, into an action plan for future practice, which incorporates a critical theory approach.

Analysis of the Service Context

The population of parents chosen to participate in this thesis were all vulnerable in terms of their socio-economic status, educational background and housing. It is widely accepted that inequalities in health and social well-being exist throughout the world and that the key debate is concerned with how to deal with these inequalities rather than prove that they exist (Lazenbatt et al 2001, Whitehead et al 1992). In the UK, the publication of the 'Black report and the health divide' (Townsend et al 1988) and its successor 'Independent enquiry into inequalities in health' (Acheson 1998) both stress the increasing inequalities in income that have left the UK with increasing child poverty. Social class, poverty, socio-economic status and deprivation have all been used to explain and theorise about inequalities in health (Philimore and Beattie 1994, Townsend et al 1988). Hyperactivity, conduct disorder and anxiety in children and young people have all been found to increase with decreasing socio-economic status (Woodroffe et al 1993). This is echoed internationally e.g. the Ontario Child health study (OCHS) in Canada identified that inequity in income increases the risk of children developing CAMH problems (Offord et al 1991).

As the population of parents recruited to participate in this thesis all had socio-economic vulnerabilities, it could thus be argued that the experiences of the parents in

this thesis such as their lack of access to knowledge can be explained through an analysis of health inequalities. It has been suggested that inequalities in health provision exist because some more 'advantaged' sections of society are more articulate and are more able to demand and access more/better health care (Titmuss 1968, Tudor Hart 1971, Robinson and Elkan 1996)

However, in this thesis, the parent's difficulties were not that they were unable to access health care. They had all had access to health care professionals sufficient to ensure that their child was referred to or was a candidate for referral to specialist CAMH services and they were all recruited from or were candidates for the waiting list, using the current service delivery criteria. The international literature indicates that only 1 in 6 children who need CAMH services receive appropriate CAMH care (Offord et al 1998, Meltzer et al 2000). The fact that the parents who took part in this research had been referred to these services is, therefore, an important feature of the sample of parents who participated in this research. However, despite the substantial access to health care and social care, which these parents had received, they unanimously agreed that they had not received the kind of support in terms of information or services, which they felt they required. Thus, for the parents in this thesis, increased access to current services alone is not necessarily going to be the most effective way of getting their needs met.

Although all of the parents were educationally disadvantaged, the 25 parents, who participated as researchers, were all able to derive a positive benefit in terms of their own self-esteem and confidence and their capacity to advocate for their children from access to and critique of the published professional literature on understanding and

managing children with challenging behaviours. Nevertheless, prior to the research, these parents had not had access to this body of knowledge. Tudor Hart (1971) proposed the inverse care law in which those in greatest need of health care received the least access to it. In contrast, this thesis seems to be indicating that increased access to health care and health and social care professionals is not necessarily the most effective way forward for vulnerable families in CAMH, but participation as creators rather than just users of health services may support those in greatest need to more efficiently take charge in getting their own needs.

At the same time however, the research reinforces the perspective of the social model, which recognises that creating health requires the social needs of these parents to be addressed, such as the need for sufficient income to enable the child to engage in recreation. The social model of health derives from epidemiological evidence and recognises that improvements in population health can only be achieved by implementing policies which tackle the root causes of inequalities in health such as poverty, poor housing and pollution.

Indeed the parents in this thesis demonstrated that although they could access targeted and relatively expensive health and social care, which did not meet their needs, their impoverished access to universally used psycho-social resources such as childcare and recreation conformed to the inverse care law (Tudor Hart 1971; Acheson 1998). This thesis indicates that access to knowledge can be a mediating influence to parents in adversity and access to the research process can help them to identify the psychosocial constraints which can prevent them from applying or maximising this knowledge and then begin to challenge services in their extant systems to provide

them. In this way, parents can become active partners in health care rather than passive victims of health inequalities, who require greater and greater access to health care, as the application of the inverse care law implies. The thesis does not aim to add to the already large literature on health inequalities, but it can increase the practice knowledge on how health care practitioners can modify their practice to acknowledge this inequality by actively engaging parents in a reciprocal transfer of CAMH knowledge.

The social model of health can be contrasted with the medical model of health. According to Locker (1997, p.247) the essential features of the medical model of health are “its focus on disease, a bio-mechanical orientation concerned with repairing disease-induced damage to the body and a narrow conception of the causes of disease and the determinants of health.....usually framed in microbiological and physiological terms”.

Sroufe (1997) has researched extensively in CAMH and proposes that the medical model is still dominant in child and adolescent mental health:

“It is sometimes difficult to recognise that the medical model with its assumptive base is being broadly applied to problems of children and youth. Its wide use partly derives from successes of the model with certain adult disorders and with occasional childhood disturbances. More general validity of the model is then simply taken for granted and not examined” (Sroufe 1997, p.254).

Sroufe (1997) proposes that the reason for the dominance of the medical model is the reliance of CAMH services on the international disease classifications. The World

health Organisation model (World Health Organisation 1993) known as the 'International Classification of Diseases 10' (ICD 10) and the American Model (American Psychiatric association 1994) known as the 'Diagnostic and Statistical Manual IV' (DSMIV) are both used nationally and internationally to underpin CAMH service delivery and outcomes. Furthermore, Sroufe (1997) proposes that the disease classification can have an impact on the construction and understanding of child and adolescent mental health and can set the parameters on the development of CAMH research and knowledge:

"The classification of childhood problems currently in use has a certain purpose in research. Categories such as Attention Deficit Hyperactivity Disorder promote communication to a degree; they summarise a set of behaviours in shorthand fashion and provide a starting point for research on aetiology and treatment. However the fact that the systems are used cannot be taken as support for their validity" (Sroufe 1997, p.256).

CAMH services are predominantly provided through the NHS. At the time data for this thesis was collected, the NHS, with few exceptions, tended to conform to the medical model of service provision, for example, the Health Advisory Service (1995) thematic review on CAMH services found that only 13% of authorities were purchasing CAMH 'in relation to the needs of the population' and 'overall purchasing was most commonly based on historical provision... only 10% used a formal needs assessment and of these, only 4 used a deprivation index' (HAS 1995, p.29). As a result of this, the HAS (1995) advocated that CAMH services needed to incorporate both social and medical approaches to CAMH. Current government policy such as the

National Service Framework (NSF) for Children, Young People and Maternity Services (DoH and DfES 2004) advocates a social approach by acknowledging the importance of a child's context in influencing health, particularly their mental health. However, as discussed in chapter seven of this thesis, the NSF does not engage in a critical debate about the opportunities and constraints of operationalising this approach in delivering complex services in the dynamically changing practice context, which is influenced by numerous variables, as the parents in this thesis have identified. The dilemmas arising from attempting to introduce a holistic social model in a practice context that is dominated by the medical model in which 'It is taken as a given that disorder arises from pathogens that are endogenous to the individual' (Sroufe 1997, p.256) are not critically debated in current national policy documents.

Bartley et al (1997) have identified the impact on health of what they term life transitions. Their evidence indicates that as individuals pass through life, there are critical periods when they are at risk of acquiring attributes or experiences, which predispose towards illness. Critical life course events and predisposing factors include: intergenerational factors such as maternal nutrition during pregnancy, unemployment, job insecurity, the onset of chronic illness and exiting from the labour market. Bartley et al (1997) suggests that without support from appropriate health and social care agencies, these events can have adverse effects on future patterns of individual and community health. Although the evidence base for CAMH includes an analysis of both risk and resilience factors in CAMH (Rae Grant 1989, Pearce 1993, Haggerty et al 1996) interventions and service provision, have tended to focus on the evidence on risk factors, which are co-related to a statistically greater likelihood of developing CAMH disorders rather than the promotion of resilience, which help

individuals to cope despite adversity (Rae Grant 1994, Plaice et al 2002). The HAS (1995) report advised on the importance of assessing both risk and protective factors (factors, which can protect against the likelihood of disorder in situations of adversity) at an individual, family and community level for children and families with CAMH issues and this was re-emphasised in the National Service Framework for Children, Young People and Maternity Services (DH and DfES 2004). There thus appears to be a tacit tension in matching the rhetoric of taking a holistic social approach, which identifies the risk and protective factors at an individual, family and community level and the medical model, which emphasises disease and deficit and risk rather than resilience

For instance in a Cochrane review of family and parenting interventions in children and adolescents with conduct disorders and delinquency aged 10-17 years Woolfenden et al. (2004, p.10) concluded that "At present there is insufficient evidence that family and parenting interventions reduce the risk of a juvenile delinquent being incarcerated or have a beneficial effect on parenting, parental mental health, family functioning, academic performance, future employment and peer relations." In undertaking this review Woolfenden et al (2004) only included evidence from Randomised Controlled Trials of health service interventions designed to reduce risk of adverse outcomes. Consequently they were unable to provide any evidence for CAMH community practice which might build on resilience factors and the guidelines for CAMH practice based on Cochrane reviews thus continue to emphasise individualised therapies, which can be easily controlled for in Randomised Controlled Trials, rather than broader, social and holistic approaches, where there are multiple and complex intervening variables coming into play.

This positivistic, individualised approach to developing the evidence base in practice can be contrasted with contemporary Government policy in CAMH, which calls for community-based multi-agency/multi professional approaches to service provision (Health Advisory Service 1995, DoH and DfES2004). These calls have arisen partly in response to the failures in specialist services to adequately have an impact on the prevalence of CAMH problems and disorders in the total population and the acknowledged difficulty that specialist CAMH services alone can ever meet the continuing high CAMH needs through its finite specialist resources (Offord et al 1998). Furthermore, the mismatch between the efficacy of empirically based treatments and effectiveness in the context of service delivery is recognised internationally (Hoagwood et al 2001). There is also increasing recognition that medical intervention occurs at a stage when the problem has become acute and therefore is often ameliorative rather than preventative (WHO 2000, Wagstaff 2002). In CAMH this general recognition of the limitations of the medical model of care is reinforced by the work of Offord and Bennett (1994) and Henggeler et al (1995), that have both adopted community approaches to their work and have begun to demonstrate longer-term improvements.

In the light of this evidence, increasing emphasis is being placed on health promotion and prevention both generally (Wanless 2002) and specifically in CAMH (DoH and DfES2004) which, it is recognised, requires coordinated multi-agency strategies encompassing integrated universal community-based provision, greater community involvement and control and more focus on health, social inclusion and quality of life (Israel 1998; Van Londen 1998). For those at risk of succumbing to the need for specialist intervention due to deteriorating health and/or social circumstances targeted,

early individual and community-centred proactive and preventative interventions are recommended (Flaskerud and Winslow 1998, Kaplun 1992).

The World Health Organisation has seen improving the capacity of families to maintain and promote family health as a key issue. The World Health Organisation (2003) reports on CAMH states: 'improving the ability of families to address potentially debilitating mental disorders in the context of the family is a key to humane care. Improving communication about emotions and involving the child in the family in meaningful ways can reduce the consequences of isolation that leads to adverse outcomes.' (WHO 2003, p. 6).

The importance of using knowledge and skills to help individuals gain control over their lives has been highlighted in the salutogenic model of health proposed by Antonovsky (1993). Antonovsky (1996) has identified what he calls 'generalised resistance resources'. This refers to the characteristics of an individual or group (family) that facilitate successful coping with the inherent stressors of human existence, including the types of life transitions described by Bartley et al (1997).

Antonovsky's work indicates that a range of social and psychological factors predispose towards the development of generalised resistance resources; these include wealth, ego strength, social support and cultural stability all of which promote health (Antonovsky 1993). These factors are very similar to the protective factors, (discussed in Chapter Two) which have been identified, using quantitative techniques of regression analysis, to protect against the onset of CAMH problems (Pearce 1993).

The salutogenic model suggests a relationship between health and people's ability to believe that 'life is comprehensible and meaningful' (Antonovsky 1993). Offord et al

(1992) have developed the concept of resilience i.e. the ability to cope despite adversity. This involves reducing the risk factors, which increase the likelihood of developing CAMH disorders and promoting the protective factors, which mediate against disorder in situations of adversity. The use of risk and resilience can help to synthesise the individual approach of the medical model with the wider context of the social model by analysing the risk and protective factors at an individual, family and community level. In addition the concepts of risk and resilience can be translated to strengths and needs, which can have a normalising and therefore destigmatising and anti-oppressive effect as all individuals have strengths and needs. Prillitenky (2001) has applied a critical theory approach to the process of resilience by suggesting that resilience be redefined in emancipatory terms as the ability to not only cope with adversity and injustice, but also to challenge their very existence.

Developing an explanatory theory of the service delivery in CAMH experienced by the 25 participating parents in this thesis.

The medical/disease focus in CAMH services (Sroufe 1997) creates a tendency to focus on risk factors, with a statistically identified link to 'disorder' at the expense of resilience factors. As discussed in the previous chapter, this points to a partial and selective implementation of the evidence base in CAMH literature and service provision, which the thesis findings indicate had adverse consequences for the parents in this study who had been referred to these services for help.

Sroufe (1997, p.257) argues that there needs to be a move from the disease focus of the medical model 'in which environment is narrowly defined as (as toxins), precursors are seen as pathogens or simply early forms of the disorder and course is

viewed as linear' to a greater emphasis on a developmental model. The developmental model focuses on researching the total set of risks, which impact on the child's development and can lead to developmental psychopathology. The parents in this thesis provided some evidence to support the developmental model proposed by Sroufe (1997). They identified, for example that their children were at increased risk of not achieving their development tasks because they had individual difficulties with information processing and that because these developmental were not being acknowledged by the child's school, the child was experiencing increased social and academic problems. Through gaining an understanding of the child's developmental needs and the risk factors, which could decrease the risk of the child achieving the child's developmental tasks, some of the parents showed that they were able to engage with the child's extant systems and advocate for their children by, for example, challenging the school's belief that their child was deliberately inattentive and were consequently able to negotiate specific help for their child. Furthermore, this changed understanding supported all of the parents to develop individual, family and community resilience by challenging the definition of the child's problem from an individual/family focus to a social focus in which the problem is also systemic and societal. This posed a challenge to universal services such as schools to recognise and respond to the psychosocial determinants of behaviour and offer a flexible range of support in response to the wide range of needs of the population of the children they were serving.

However, not all of the parents were able to use their increased access to developmental psychology literature to achieve a change as they found some schools operated on a philosophy that all children needed to adhere to the norms of behaviour

and when they failed to do so, they were either naughty or they had individual psychological problems. Psychology has traditionally focused on the individual level of analysis and most of the major theories of personality and clinical psychology emphasise individualistic explanation of behaviour and individual strategies of change such as psychotherapy (Prillitensky 2003). The parents' experiences illustrated that achieving a wider and flexible response to their children's needs depended not only on gaining access to knowledge but also in critiquing the medical model and psychological model of CAMH and the wider set of social assumptions underpinning these individualistic approaches to service delivery. As discussed in the previous chapter, analysis of the findings suggests that the parents in this thesis appeared to be affected by a number of tacit assumptions which seemed to be taken for granted by service providers and embedded in the dominant model of service provision. Both the medical model and the historical focus of psychology on self determination and health use research based on positivist principles in which causes for ill health are located at the level of the individual and therefore do not pay attention to democratic participation or to social justice (Fox and Prillitensky 1997). These models can serve to legitimate the tacitly oppressive assumptions identified by the parents in chapter 6 and include:

1. A tacit assumption that experiential knowledge and skills arising from the direct care of children over 24 hour or significant periods, are inferior to the knowledge and skills of professionals which are underpinned by positivistic science and validated by "legitimated qualifications".
2. A belief that social norms are a given and not a construct means the child is only exempt from them if they have an illness or disability, that is recognised

by professionals, who have the legitimated qualifications to diagnose deviancy from these scientifically derived norms

3. A tacit acceptance of the appropriation of knowledge and science of care by professionals removed from the day-to-day practice of providing 24 hour care or significant periods of care in the 24 hour daily space.

These will now be discussed in turn to develop an explanatory theory of the parents' experiences that can then be challenged and changed from the perspective of critical theory and emancipatory research and practice.

1. Caring skills are inferior to professional knowledge

A tacit assumption identified within this study is that knowledge and skills arising from the direct care of children over 24 hour or significant periods are inferior to the knowledge and skills of professionals which are underpinned by positivistic science and validated by "legitimated qualifications". Rolfe (1998a, 1998b) discusses the tensions for nurses in which their professional credibility as carers, who provide an individual care approach derived from the individual context and their experiential knowledge, can conflict with their professional requirement to provide an evidence based approach that is derived from empirical research and applies generalisable findings, because policy makers, such as the Department of Health, explicitly place a higher value on the evidence base derived from the Randomised Controlled Trial than from experiential evidence grounded in everyday care. A potential consequence of this assumption is that the greatest power over the creation and dissemination of knowledge related to children with disruptive behaviour problems is invested in professionals, who engage in the least amount of their "direct care". Thus professionals such as policy makers, who do not have access to the continuity of the child's daily life or psychiatrists and psychologists, whose access to children tends to

be limited to therapeutic episodes or limited daily/weekly access, appear to be ascribed the greatest power over definition of the problem and access to the resources to respond to the problem.

Professionals involved in significant amounts of direct care of children, whose knowledge is experiential and frequently tacit, may thus be proportionately less empowered in defining the problem or in determining access to resources. For example, the residential CAMH nurses in the nursing study upon which this thesis is built (Croom 1996), described in chapter five, were not initially able to articulate an underpinning theory for their care and reported feeling “relatively inferior” in multi-disciplinary meetings because of this. Parents identified with this, when they unanimously agreed that they felt inferior to professionals with qualifications. However, the parents identified that this could also apply to other professionals, who acted as significant adults providing care. For example the parents identified the significant care role of teachers carried out by teachers, who care for their children for significant proportions of each week. The parents proposed that in their experience, the teachers also seemed to have a relative lack of access to CAMH information and yet they could also experience simultaneous blame if they could not handle their children in class. The parents identified that in their experience, teachers’ prestige depended on being able to deliver the syllabus rather than to “care” for their children. A perceived consequence of this was that the blame for a teacher’s failure to care was frequently projected onto them as parents. Parents in this thesis, who carried out the most direct care, were the least likely to possess or have access to the legitimated knowledge required to define their child's problems. They reported the greatest difficulty of all in feeling able to challenge professional decisions or access resources.

Mother blame was discussed extensively in the previous chapter and this thesis provides practice evidence that indicates a theoretical link between the invisibility of knowledge and skills associated with care (Procter 2000; Rolfe 1999a) with the degree of mother blame (Caplan 1998). The experiences of the parents in this thesis indicated that this is perpetuated by a poor access to legitimated knowledge that is experienced by carers that makes it difficult for them to challenge the services available to them.

2. Assumption that norms are a given and not a construct: Establishing the 'norms': the role of labelling and diagnosing in defining access to services

The theoretical foundation of much of the CAMH research, literature and diagnoses is located in the definition of disease, which is manifest when the child deviates from the developmental norms (Sroufe 1997). Sroufe (1997) argues:

“When maladaptation is viewed as development rather than a disease, a transformed understanding results’, because it opens up the possibility of viewing psychopathology as a consequence of maladaptation, which is open to change rather than a fixed syndrome” (Sroufe 1997, p.260).

Although Sroufe’s proposal has the advantage of increasing the likelihood of change, it does not address the socially constructed nature of developmental norms.

Furthermore, the socially constructed nature of norms is not acknowledged or addressed in child and adolescent mental health research or policy documents such as the National Service Framework for Children and Young People (DoH 2004). Thus, although there are advantages to taking a developmental perspective, as discussed by Sroufe (1997), developmental psychology can also be critiqued for failing to take into

account the impact of the social context on development (Burman 1997). Many of the early developmental theorists, such as Piaget (1973, 1976) and Freud (1964) whose work still informs CAMH developmental perspectives and texts (Slee 2002; Bee 2004), are biologically driven and even those which incorporate a social perspective such as Erikson (1963) assume that individuals follow an innate pathway/set of developmental tasks that they need to achieve in order to meet their developmental maturity. Later research on development such as Crick and Dodge (1994) are still underpinned by biological and maturational assumptions. However, the assumption that development is driven by an innate striving towards maturity rather than resulting from power struggles, fails to acknowledge that behavioural norms are 'ethnocentric, andocentric and patriarchal and therefore serves the interest of dominant groups... to the extent that instead of poverty, unemployment and frustration, we have evil children, bad mothers and broken homes' (Burman 1997, p.134).

In moving from empirical evidence to CAMH practice, through the use of a practitioner research and critical theory approach employed in this thesis, it is necessary to challenge the social construction of child rearing implicit in the mainstream evidence that currently informs CAMH practice. This construction derives from statistical techniques, which measure deviations from a norm, that is pre-determined by dominant groups and thus creates normative descriptions of child behaviour under the guise of scientific descriptions (Burman 1997). The dominant scientific paradigm (which currently governs CAMH practice) can be argued to maintain the status quo by propagating the belief that what dominant groups prefer as the desirable way to raise children is the natural way (Burman 1997). The difficulties experienced by CAMH services in accessing families most at risk and the high

dropout rate by those who do attend, described in chapter two and experienced in the recruitment of parents to this research, may in part be attributable to the oppressive nature of the normative behavioural assumptions which underpin much of CAMH evidence and practice. It is possible that families most at risk recognise they cannot conform to these expectations and norms and must, therefore, continue to fail. Rather than face persistent failure and the consequences of this for their self-esteem, they opt out.

It is thus possible to 'conceive of psychology as the science of normative behaviour. Human beings are envisaged as unique in their socially acquired skills to construct, identify and use complex normative systems as guides to behaviour. Such normative influences involve norms and rules that prescribe correct behaviour for people in given settings' (Moghaddam and Studer 1997, p. 187).

Using the medical model and psychological model as a basis for CAMH practice appears to have created a professional constitutive meaning which defines the social norms and behaviours related to child and adolescent mental health, identifies the accountability and blame for children deviating from these norms and dictates the kind of responses, which will effectively deal with the problems related to deviation from the norms. By extending Burman's (1997) critical perspective on developmental psychology, it is possible to explain how the power ascribed to professionals with "legitimated knowledge" that has been derived from rigorous scientific research, may silence any debate on the wider understanding of CAMH issues and the definition and parameters of behavioural norms, which then become accepted as a "given" rather than a "construct" or an "interpretation".

The tacit and contradictory assumption that a norm is a given can succeed in maintaining carers in an oppressed position through the generation of a social consciousness or philosophy that if a parent has a child, who consistently does not conform to the prevailing norms, then they must be failing in their parental role to effectively nurture and manage their child. Such an assumption relieves society and its systems from their responsibility to explore the social explanations and accountability, which the participating parents in this thesis highlighted, were critical.

It would appear that the only exemption from or attenuation of the blame ascribed to parents occurs if the child is assessed as having a predefined disorder or disability. As psychiatrists and psychologists are ascribed the role of diagnosing disorders or interpreting psychological testing, their power is continually reinforced and legitimated. The parents illustrated the practice impact of this oppression, when they reported feeling as though they are constantly “banging their heads off a brick wall” to get their children’s needs recognised and so their sense of powerlessness becomes progressively reinforced.

3. The appropriation of the science of care

The findings have illustrated that the complex and sophisticated skills of 24 hour care are difficult to articulate by carers such as nurses in the previous study upon which this builds and parents in this study and often remain tacit. In taking an individualistic approach, psychology and psychiatry have extensively researched some of the micro-skills involved in care, such as the skills involved in attachment or communication. This has enabled them to claim a dominant position over the science of care by

defining it as therapy and thereby maintaining the status quo of their ascribed power as professionals.

For instance, there is a huge literature base on attachment and this is used to underpin all aspects of psychotherapy. This thesis indicates that the literature base on attachment is useful in providing a tool to interrogate the tacit and intuitive skills of the caregiver/child relationship and can be used by parents to help them develop solutions in their everyday care, in which their relationship with their child is the key to management. However, the parents illustrated that the information on attachment was not shared with them prior to the research. Furthermore, they found that in order to apply this to their everyday context, it was necessary to critique the literature on attachment through the social justice/critical theory lense in order to understand the psychosocial process of attachment, which then enabled them to challenge society to provide a supportive context or milieu in which the art of care and attachment could be enacted. Appropriating the science of care, through legitimated scientific concepts arguably legitimates the professional power to direct and define care for those who carry it out. However, gaining access to this 'expert' language helped the parents to develop insight, articulate their tacit knowledge and thereby gain the confidence to challenge professionals with 'legitimated qualifications'. The devaluation of care and the power of therapy can also be explained from a feminist perspective in which care is associated with mothers and thus devalued in a paternalistic society, whilst the science of therapy is legitimated from a male power base (Caplan 1998). This thesis does not aim to add to this substantial feminist literature, but uses the overarching perspective of critical theory to recognise the practice implications of power

relationships in CAMH, which can arise from both access to knowledge and gender, in order to challenge and change these relationships.

An alternative caring model merging from this research

Under the aegis of the medical model, psychology and psychiatry have conceptualised problems in individualistic and intra-psychic terms. This can lead to an assumption that psychological interventions can be potent enough to undo the damage of structural inequality. This means that social factors and inequities of employment, housing and socioeconomic status on CAMH services do not need to be addressed. Critical theory helped to conscientise (Freire 1993, 1995) the parents participating in this thesis to the oppression and injustice of the current configuration of CAMH services.

Falk-Rafael (2005) has developed the concept of critical caring which she suggests has the potential to root public health nursing practice in an expanded nursing caring science. This reincorporates the social justice agenda characteristic of early public health nursing practice, which she argues is absent from much contemporary nursing theory. The reintegration of the social justice agenda and the development of the concept of critical caring clearly require a critical social theory approach to research, which is concerned to address these contradictions.

Access to critical social theory allied to action research used and a supportive group milieu appeared to help the parents in this thesis to develop the conscientisation (Freire 1998) to challenge the dominant knowledge base in an emancipatory way as opposed to experiencing it as another source of oppression. According to Habermas

(1973 and 1979) a social critique, which is useful in liberating individuals and groups from domination, must be aimed at the fundamental structures and ideologies of social systems because such structures define how privilege, exploitation and powerlessness are distributed among persons and groups in society. Stevens (1989, p.58) discusses how 'racism, sexism, classism, ageism and heterosexism are some of the fundamental dogmatic ideologies that are internalised in social structures and thus operate in unexamined ways'. This thesis, which focuses on care and practice in CAMH, indicates that '*care-ism*' could be seen as another tacit ideology, which can produce exploitation and powerlessness.

The findings from the parents indicated that the CAMH services being offered to the parents were using the model of the helping professionals by attempting to provide decontextualised care, which fails to confront the social injustice that can undermine their work. Prillitensky (2001) proposes that health and social justice are inextricably linked. However, the historical focus of psychology and psychiatry on self determination and health has meant that little or no attention has been paid to democratic participation or social justice (Fox and Prillitensky 1997) As long as problems encountered in daily living are attributed to the CAMH problems/disorder itself, efforts to enhance health are conceptualised and enacted at the individual level. The experiences of the parents in this thesis indicate that in CAMH, this can lead to CAMH services adopting an explanation of pathology and blame at the level of the parent or child rather than taking into account the social conditions. Although there is a CAMH evidence base that adopting a multi-systemic approach, such as that discussed by Henggeler et al 1995 can challenge services to take a more holistic, it

requires a paradigm shift in service delivery, that was not available to the parents of this thesis and which has not been nationally adopted yet in CAMH service delivery.

The thesis indicates that a further paradigm shift is needed for both nursing and CAMH services, in order to move to an empowerment approach. There is a considerable literature on empowerment in adult mental health (Freund 1993; Gilbert 1995, McClean 1995). Despite this literature, very little work has been undertaken which explores how health professionals move into an empowering role (Musker and Byrne 1997). Byrne (1998) proposed that 'The move to an empowerment approach requires a paradigm shift for nurses, many of whom have been trained in schools and have worked in service environments that uphold altruistic but demeaning notions and practices of servicing client deficits. The shift [to empowerment practices] involves acknowledging and reducing the power imbalance between the professional and the consumer. It involves understanding the meaning the consumer gives to their lives. It means meeting the consumer on his or her own turf. It involves struggling with the discomfort of sharing control and understanding differences between the culture of the professionals and those of the consumer' (Byrne 1998, p.69).

In taking an evidence based approach, which is informed by the Randomised Controlled Trial methodology, both nursing and CAMH practices are encouraged to adopt an expert stance towards patients focusing on identifying and meeting the needs deficits of patients and clients and 'best practice' to respond to these needs. This implies that nurses and CAMH practitioners have superior knowledge and skills and are able to meet the deficit and so create health in patients and clients. This stance is simultaneously altruistic and disempowering; it satisfies professional needs to justify

their intervention, but does not require professionals to engage with the realities of the social situation, which creates complexity in the lives of patients and clients. Instead patients and clients receive de-contextualised support and education, which they have to translate into the complexity of their daily situation.

The parents' findings resonated with the findings from the nursing study (Croom 1996) discussed in chapter five, in which nurses described that prior to their access to the legitimated knowledge base related to care, they had felt disempowered relative to professionals, who did not engage in direct care (but who had appropriated the 'science' of CAMH care through the theories of psychology and psychiatry). Once the nurses acquired the dominant language themselves, they could not only articulate the sophisticated process of care more successfully, they could identify and disseminate their powerful and strategic position in being a carer for a child throughout their 24 hour life space, as opposed to another professional, who may only see the child on a sessional basis.

The parents in this thesis illustrated how access to the legitimated CAMH knowledge base using a critical perspective, helped them to recognise their tacit knowledge that their child needed help, which they felt had previously been silenced by the tacit assumptions, discussed above, that parents who cannot make their children conform to the social norms of behaviour are inadequate and that children who do not conform to the norms are naughty/bad. Without the access to the legitimated knowledge base, or to the research methods, which can support them to challenge the tacit assumptions, which maintain the status quo, the parents had experienced guilt and punishment as identified in the findings. Professionals and policy makers, however, who possess the power to define the norms, also have the power to ascribe blame,

which serves to silence any debate. Developing the group consciousness within each parent cohort gave them the confidence to challenge the status quo and it is argued in this thesis that this:

'Holds the key to understanding the constraining environmental factors affecting people's health and provides the potential for transforming the conditions which hinder human potential' (Stevens 1989, p.66).

Developing care, self determination and social justice in CAMH

The process by which the parents were supported to develop empowered care for their children, through accessing the literature which helped them to tune into their child's particular behavioural style and to challenge the current systems of care, through being involved in the participatory research process can be further theorised with reference to temperament.

The parents in this thesis all identified that their children had a temperamentally very challenging profile of behaviours as defined in longitudinal temperament research such as that of Thomas and Chess (1977) and replicated by Sheeber and Johnson (1992) and Sheeber and McDeevitt (1998). Such research has identified that there is a normal distribution curve of temperamental behavioural traits in the population.

About 40% of children have temperamental traits which mean they are naturally predisposed to be easy going and able to cope with new situations. These children tend to elicit positive responses from their significant caregivers. About 10% of children can be described as having a challenging temperament and tend to elicit more negative responses from caregivers, because they tend to be negative in their mood, are unpredictable and tend to have difficulties adapting to any new situation. About 15% of children were described as slow to warm up children because they tend to

withdraw from activities and adult caregivers can also find this behaviour more difficult to cope with. The remaining 35% of the population lie in between these extremes. Both extremes of temperamental types of behaviour i.e. challenging and slow to warm up can provoke problems in social situations if the adult carers, across a range of situations such as school, home or leisure activities, are not sufficiently tuned into the child's particular profile of traits, that they are able to support the children to cope with everyday situations and frustrations (Thomas and Chess 1977, Sheeber and McDeevitt 1998).

By being encouraged to explore a social approach to health, the parents in this thesis were able to analyse the construct of norms in relation to temperament. The parents were also encouraged to take an emancipatory/critical approach (Fontana 2004, Khanlou and Peter 2005) to challenge the universal services their children were receiving, such as school and leisure services to provide equity of service provision that meets the needs of the total population distribution of temperamental traits and not just the easy going children, who are easier to cope with.

Research by Thomas and Chess (1977), Chess and Thomas (1996) and Turecki and Tonner (2000) has identified that a challenging temperament only poses an increased risk of a child developing CAMH/ behavioural problems or at least being labelled as difficult when there is a mis-match between a child's temperament and the capacity of the carers, be they parents, teachers or child-minders to respond to the child's individual temperamental needs. The 25 participating parents all described how they had difficulties in getting help for their children as initially none of their children were acknowledged or judged by professionals in universal settings such as schools, to

have specific temperamental needs, which required a specific and sensitive response from their caregivers, but instead were considered to be difficult and in some cases obstructive. Findings from this thesis illustrated how the mismatch between the children and their carers, resulted in an incremental accumulation of risks for the child, arising from low self-esteem and feelings of helplessness as problems increased.

Sharing the research on temperament with parents illustrated how providing parents with access to and an understanding of empirical research literature could emancipate parents and children by enabling them to identify and then challenge the oppressive assumptions, that children with an innately challenging temperament were being deliberately difficult and their parents were inept, which the parents in this thesis felt were tacitly embedded in and informed the services they used.

In order to achieve this emancipation, the findings demonstrate how understanding the literature on temperament and the findings from this literature, enabled the parents to cognitively reattribute their own beliefs about their children as “deliberately winding them up” to children who need particular help to cope with their particular set of temperamental traits. Having come to this realisation themselves through their reading of the literature, the parents were left wondering why professionals whom they felt should have had access to this literature through their professional education and development, hadn’t similarly arrived at the same conclusion. This relatively simple level of analysis was sufficient to enable the parents to embark on a critical analysis of their experiences of service provision and to move from a framing of themselves as inadequate parents and their children as deliberately ‘naughty’ or ‘bad’ to parents

whose child's needs had not been identified and met by services provided to care for them.

However, the parents illustrated that although access to the developmental literature on temperament was useful, it was not necessarily sufficient to support them to achieve systemic change. Although they could understand the implications of the literature on temperament for the care of their children, altering their own parenting behaviour in line with their new understanding was not straightforward. The parents found that in order to be able to effectively interpret and apply the information on temperament, they themselves required psychosocial support in order to stay sufficiently emotionally neutral in challenging conditions and to be sufficiently emotionally available to be able to tune into cues regarding their child's temperament. Furthermore, parent's experiences indicate that their children were receiving care from services, which appeared to assume that a very narrow distribution of temperamental behaviour was 'normal', despite the evidence base on temperament, which demonstrates a wide distribution of temperamental traits in the normal distribution curve of the population (Turecki and Tonner 2000).

This is illustrated in Figure 5 which applies the research of Thomas and Chess (1977) that has been replicated (Sheeber and McDeevitt 1998). Figure 4 illustrates a normal distribution curve of temperamental behaviour in children across the population.

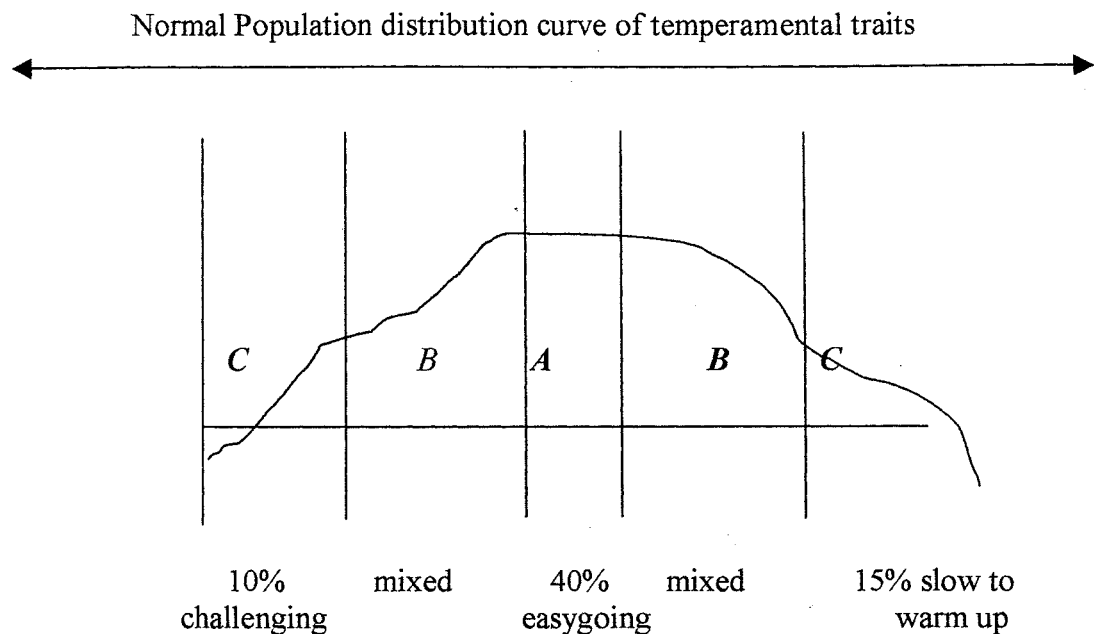
Diagram 4 illustrates the perceptions of the parents in this study that:

- a) The current construction of behavioural norms, indicated by the parents in this thesis, which were employed for example by universal services i.e. available to all (Offord et al 1998) such as primary health services, schools and leisure services

are too narrow. This is represented by area A in Figure 5. This means that universal services tend to respond to a narrow section of the population and services such as schools and leisure services are focused on a relatively narrow set of norms. This could explain the parents' perceptions that they found it difficult to help their children to enrol in leisure activities because they were not well behaved enough. Similarly children who for example, could not sit still in class were more likely to be labelled as disruptive rather than being seen as having a particular set of needs related to difficulties in changing activities and that such behaviours could be included in the normal distribution curve of behaviours and which would therefore, merit a response from universal services.

- b) Children with extreme needs, represented by area C (figure 5), may get help from specialist or clinical services if they can circumnavigate the system and be designated as special education needs, or as mentally ill.
- c) Children who are more challenging (represented by area B) i.e. outside normal acceptable behaviour area A, but who do not meet the criteria of C (either because they are not severe enough or have not been through the diagnostic processes), are thus often left with unmet needs and their difficulties can escalate until they can be classified as C and get their needs met.

Fig 5 - Normal distribution curve of behaviour to illustrate how current system can leave children with unmet needs



Using the work of Thomas and Chess (1982) we might estimate that up to 60% of children fall into areas B and C, the proportion of these in either B or C will depend on the local capacity to recognise temperamental needs and the local diagnostic capacity. Offord et al. (1998) have proposed that it is necessary to provide an optimum combination of universal (i.e. available to all) targeted (available to those with specific risks) and specialist services (for those with identified disorders). However, Offord et al (1998) do not specify what the optimum combination would be or how it can be determined.

Applying the tiered model recommended by Offord et al (1998) it can be deduced that a wide range of children, who have more challenging behaviours, which are constructed to be outside of the socially acceptable behavioural norms (i.e. area A) can be considered to be more at risk if significant adults do not respond to their needs and thus may require targeted, interventionist services. However, if there are not

sufficient resources to cope with these children, their behaviour may need to deteriorate before they can receive appropriate help or their needs may not be recognised, leading to a poor prognosis for the future.

If, however, the focus of the medical model which emphasises individual risk is augmented by the evidence on risk and resilience (Rae Grant 1994, Plaice et al 2002) which implies a more social model of health it can be seen that this incorporates a much more flexible and diverse range of perspectives, which leads to a wider construction of behavioural norms than found in Figure 5. By widening the construction of behavioural norms, the needs of more children would be met by universal services. This could increase the total systemic capacity to meet the needs of these children by widening the access to, for example, universal leisure services, which, as discussed in the previous chapter and the literature chapter, and are known to be both more cost and therapeutically effective (Browne et al 1999, Knapp et al 1999). However, as the parents in this thesis found, it can be difficult for their children to access these services because the parents describe how their child's behaviour is viewed as disruptive by the public and leisure services rather being on a spectrum of temperamental behaviour or parents simply cannot afford them.

Such a widening of the construction of norms may well require increased support to universal services. The tiered system of CAMH services (Box 1) recommended in UK policy documents (Health Advisory Service 1995) described in the literature chapter and supported in the recent National Service Framework for Children (DoH and DfES 2004) appears to be attempting to achieve this optimum combination of universal, targeted and specialist services. However, there has been no debate in the

CAMH literature about how the construction of behavioural norms can determine the proportion of children considered to require the services of each tier. Nor has there been any debate about how current provision and the distribution of resources between services locally can impact on demand.

Furthermore, the tiered service model (Box 1) accepted by the National Service Framework (DoH and DfESb2004) describes professional responses and does not debate the potential contribution that parents as carers can make if they are given adequate social support to respond to their children with emotional and behavioural needs.

The findings of this thesis indicate a process whereby normal (in terms of the normal distribution curve of a population), but challenging childhood behaviour arising from their unmet temperamental needs may have to be pathologised in order for parents and children to gain the support that is required to avoid the psychopathological pathway of cumulative risk such as exclusion from mainstream services such as education and leisure facilities. Although radical critiques of the processes of labelling and diagnosing adult mental health have been available since the 1960's (Samson 1995) a search of the literature has not revealed a similar critique of CAMH services. Here the prevalence of CAMH disorders discussed in chapter two and found to be increasing in most western societies may well turn out to be a product of the capacity of universal children's services, such as education and leisure services, to accommodate the wide spectrum of normal childhood behaviours.

It could be argued that there is a need to incorporate more sophisticated debates about how behavioural norms are constructed and maintained through professional practice and internalised in lay practice, such as that emerging in this thesis, to effectively implement the tiered approach. The emphasis on 'normative systems' identified by Moghaddan and Stuber (1997) can lead to power disparities. As Moghaddan and Stuber (1997) recognise, some groups enjoy more power than others in shaping normative systems. Through such power, dominant groups can influence the behaviour of minorities. Thus 'psychology as the science of normative behaviour is in part concerned with how dominant groups maintain and extend their favoured position through manipulating normative systems' (Moghaddan and Stuber 1997, p.187).

There is a growing body of theoretical literature on the construction of developmental norms in child development. However, the practice and population implications of adopting these norms as the basis for diagnosing the behaviour of children and determining access to CAMH services is only just being recognised. The findings from this research provide a clear picture of the parents' experiences in negotiating these norms in order to gain access to appropriate services. The findings can therefore provide empirical evidence of the potential impact of uncritically applying social and developmental norms, defined by experts, to a group of vulnerable parents, whose children have behavioural problems. This challenges services to acknowledge that:

"In the case of developmental psychology, we adopt a 'natural' metaphor and view deviations from socially constructed norms as 'unnatural'. We forget that our views

about development and growth are not natural, but saturated with politically charged rhetoric about power and social arrangements”.

(Burman 1997, p. 138)

Developing service capacity in CAMH

The findings from this study would suggest that the medical model and the social model of health give rise to two very different structures for identifying provision and delivery of services.

As discussed, the medical model focuses on individually focussed specialist interventions based on normative criteria of child development, the use of diagnosis and evidence from experimental studies of the effectiveness of interventions. This model has difficulty both incorporating parental knowledge and facilitating parents to engage in the creation of knowledge, as parental knowledge has not traditionally formed part of the legitimated knowledge base (underpinned by positivist philosophy) that is used to inform the practice of medical health professionals.

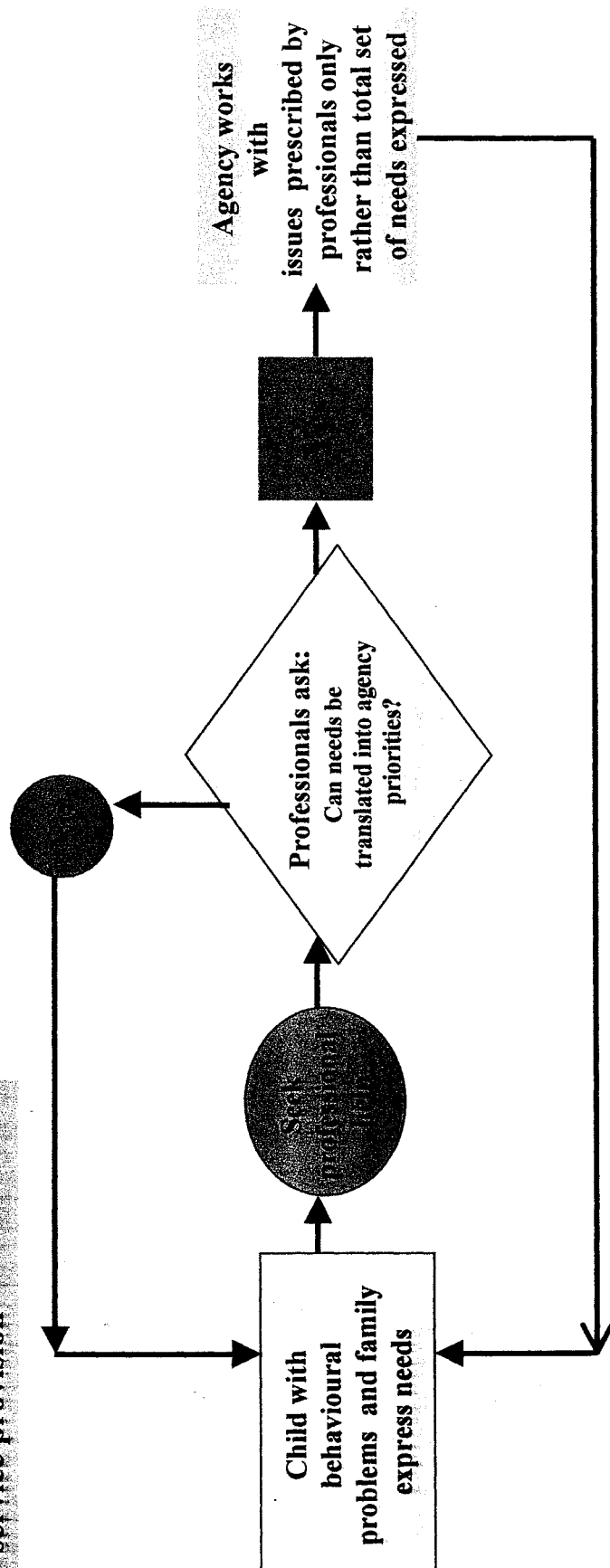
As the parents in this study illustrated, their lack of access to and the creation of “legitimated knowledge” can lead to a sense of carer disempowerment, which can reduce their capacity to care or to optimise their skills to respond to their children, in what they identified can be highly demanding situations. In turn, professionals’ lack of access to the carers’ knowledge can lead them to prescribe responses, which are consistent with legitimated knowledge derived from decontextualised research such as the randomised control trial. This positivist reductionist perspective, combined with the context of finite resources, tends to force services to ask the question ‘What

Fig. 6

CURRENT SITUATION:

Theoretical model grounded in thesis findings arising from application of current model of service provision

(End product is persistent expression of needs)



evidence based interventions can specialist services offer', because their aim is to maximise their finite resources by minimising demand, rather than consider 'What does the child and family need and how can that be provided for across the total set of extant services, which the family are involved with?' This was graphically illustrated in chapter six, by the parent, who requested respite care, but was given a modified bath, which she did not feel she needed, because that was what the services could actually provide for a child with spina bifida.

The parents in this study have identified that prescribed professional responses do not seem to meet their social and contextual needs. This means that the demand on the system by the parents will potentially increase as they continue to seek help or deteriorate to a point where they do require more specialist help. This can explain the parent's desperate claims of feeling as though they have been hitting their heads off a brick wall trying to get appropriate services, despite having had access to a range of services prior to engaging in the research.

The impact of a medical model as opposed to a clients' needs led service as indicated by the experiences of the parent in this thesis can be represented by the flow diagram in figure 6 (opposite). In figure 6 (opp. p. 377) the child/family expresses a set of needs. The service can only respond with a limited prescribed set of responses, which have been identified as effective in the evidence based literature and which are compatible with the medical and psychological model, which 'has traditionally focused on the individual level of analysis' (Prilleltensky and Prilleltensky 2003, p.244). When problems are defined in terms of individualistic conceptions of human nature, there is a tendency to engage in blaming the victim, who is held responsible

for the cause of their problems (Prillitensky and Prilletensky2003). The tendency to engage in mother blame and child blame emerged in the findings and was discussed in chapter seven. The findings identified that the individually focused evidence base, for example on information processing and attachment, which the parents found helpful in understanding and tuning into their child, had not previously been shared with them. Furthermore, the medical focus on problems can put people in a subordinate position to whoever is making the categorisation or diagnosis and make it unlikely that the parents will challenge the 'expert' medical opinion (Prilletensky and Prilletensky 2003). This can lead to services limiting themselves to working with children and families and perpetuating the status quo. This will meet either none of the family's needs and so increase the demand as the parents continue to search for help, or meet only some and thus increase the likelihood that the client will then put further demands on the service to get their actual demands met.

Work with the participating parents in this study has identified an alternative way of working in which:

- 1) Parents increase their sense of self determination and autonomy through access to literature
- 2) Parents are supported to apply this literature to tune into their child and provide care for them
- 3) The psychosocial needs of the child and family are acknowledged, for example for recreation, respite and groups
- 4) The parents become participants in the creation of knowledge in which they use their experiences to develop new knowledge related to their context and

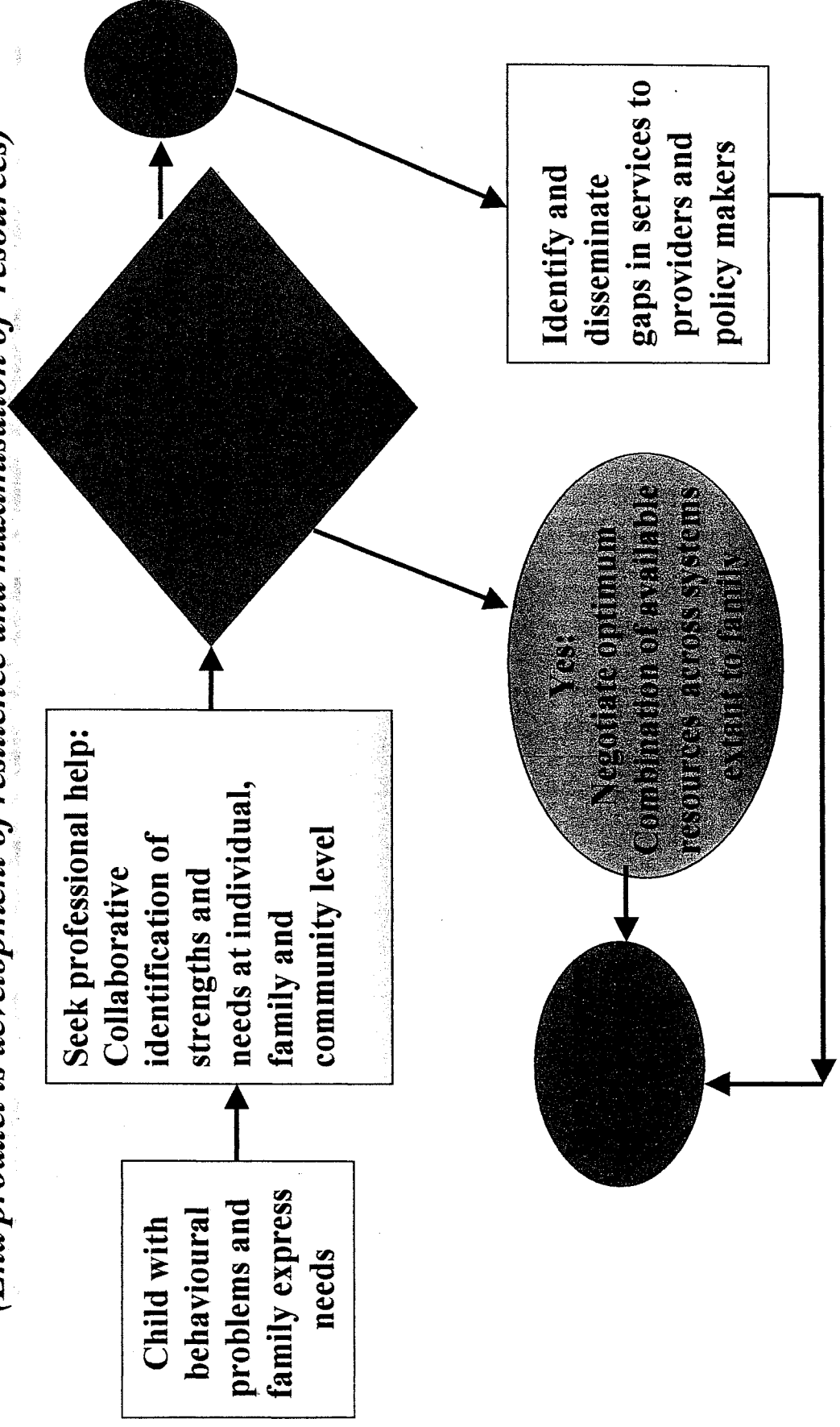
also challenge the oppressive or unjust assumptions that serve to oppress them and their child.

- 5) Parents are recognised as a resource and possessing strengths rather than solely as individuals who have problems and deficits that must be fixed.

This provides an alternative paradigm to either exclusively taking the individualistic medical way of working, which fails to take into account social context or exclusively taking the social model, which fails to take into account individual care. Combining individual and social care is currently being theorised and explored in services in North America through community psychology (Prillitenky and Prilletensky 2003) and critical care (Falk-Rafael 2005). Although there is no unitary definition of community psychology, there is a consensus that it offers an alternative paradigm to the traditional individual focus psychology by focusing on the fit between the individual and their context, the importance of diversity, which supports an individual's right to be different without risk of suffering material or psychological sanctions and a focus on social change towards a maximally equitable distribution of material and psychological resources (Prilletensky and Prilletensky 2003). Falk-Rafael (2005) identifies critical caring as the combination of individually focused care with critical theory in which any injustice in the social milieu, which affects care, is challenged. It would appear from this thesis however that the services accessed by the participating parents in the UK were medical and individually focused at the start of the research. However, through engaging as participant researchers, the parents were able to help develop an alternative model by integrating the caring, social and critical perspectives advocated by Falk-Rafael and the critical theory perspective of community psychology (Prilletensky and Prilletensky 2003). Critical care and

Figure 7 Theoretical model, grounded in thesis findings, illustrating potential way forward by applying participative approach with parents in which there is a collaborative identification of risk and resilience with family and family's extant systems

(End product is development of resilience and maximisation of resources)



community psychology appear to be adopted more in the USA and Prilietensky and Prilietensky (2003) propose that the difference between North America CAMH development and Europe are possibly due to the closer alignment with the European psychologists such as Freud and Piaget in Europe. It is crucial, therefore that CAMH service providers critically explore the underpinning philosophies of service provision and their impact on the construction of health and health responses.

This thesis indicates a relationship between the model of health care used to provide services to children with behaviour problems and their families and the total system capacity to be able to respond to the children and families. The flow diagram in Figure 7 (opp. p 380) illustrates the alternative way of health care espoused by Falk-Rafael (2005) and Prillitensky (2003). This involves working collaboratively with parents to develop a shared body of CAMH knowledge, which facilitates a holistic understanding of the child and family profile of needs and strengths. It thus integrates the essential change process, identified by the parents, in which services work collaboratively with parents to ask, "What kind of services do children and families need?" Responding to this question requires an approach, which acknowledges the situational and temporal variability in an individual family's strengths and needs and the need therefore to build a flexible set of responses, which acknowledge the child and family's individual, family and community strengths, (but do not use these as a way of minimising their access to service provision) and fully listen to their perceived needs. It also integrates the parents expressed needs for a wide variety of psychosocial supports such as parent groups and access to leisure, recreation and respite care.

Whilst parents recognised that resources are limited, they also identified how extra information and support can facilitate more effective use of available community resources. The feed back loops inserted in the diagram illustrate the need, identified by the parents in this study, to have access to ongoing support, which they can proactively access when their needs outweigh their strengths. The application of the practice model used with the parents in this thesis, which is collaborative and systemic, can potentially operationalise the recommendations in CAMH literature and policy that services should focus on reinforcing and strengthening resilience as a way of reducing risk (Rae Grant 1994, Offord 1996, DoH and DfES 2004). This can increase the total capacity to respond to CAMH problems by optimising all resources at an individual, family and community level and thus only using expensive specialist services, when these other options have not proved effective.

The parents in this thesis, who all had children with significant behaviour problems, illustrated the therapeutic benefit of relatively cheap recreation and recreational activities for their children. In addition, this new model of working incorporates Prilietensky critical concept of resilience as not just as a way of coping with adversity, but also of challenging the adversity (Prilietensky 2003)

The above analysis suggests that the model of practice dominating service provision was instrumental in determining access to and organisation of services experienced by these parents. This service model had not been able to accommodate the health care practices required to facilitate access to the full range of services required by these parents; nor did it enable health care practitioners and providers to recognise the impact of developmental norms on determining access to services and the need for

service providers to critically review the assumptions underpinning child behaviour which govern the cultures of universal services such as schools and leisure facilities.

This alternative practice model assumes that developing services which incorporate the full range of evidence in CAMH, rather than focusing on risks while ignoring the evidence on resilience, will lead to an increase in the overall capacity in the system, without necessarily increasing demand for specialist resources. It is theorised that this is because better use is made of professional's time as professionals are not expending time on assessing a family in order to exclude them from current provision and then re-assessing, as the family is re-referred in a continuous negative cycle of demand and refusal or inappropriate supply.

Figure 7 highlights the potential summative impact on the capacity of the total system to respond to children with behavioural problems by working collaboratively with parents to develop a cumulative practice knowledge and skills base that is derived from psychological and psychiatric literature, the parents' inductive analysis of this literature and from an analysis of the parents' experiences.

There is a need for further research with a larger population to empirically test the theoretical propositions on the community capacity to respond to children with challenging behavioural traits, emerging from this thesis.

Parental contributions to the cumulative body of CAMH practice knowledge

During the course of the research the parents were also able to develop further insight and knowledge and therefore capacity by identifying three other factors, which could increase the risk of vulnerable parents:

- (1) The way parents made sense of their situation. If they attribute their situation to their inadequacy or their child's behaviour to their naughtiness (as they tended to at the beginning of the research), then they were more likely to be oppressed by social attitudes while being passive victims of social penalties. However, if they made sense of their situation by acknowledging that their child had genuine needs and that they had rights as carers, and then they were able to challenge the status quo and optimise the resources available to them and thereby build resilience to cope with their challenging situation.
- (2) Neighbourhood harassment. All of the parents reported being subject to neighbourhood harassment, which was associated with neighbourhood scapegoating of their child's behaviour. At the beginning of the research this caused a great deal of distress and increased the child and family risk. However, at the end of the research, the parents in each cohort were all able to challenge the justice of this and to recognise that additional social support like community education on CAMH and widened access to recreation for a wide spectrum of children, would help their children and them as families to cope despite adversity.
- (3) School Gate syndrome. The parents all unanimously reported school gate syndrome, where they felt humiliated by being told publically, about how badly their child had behaved that day. This daily ritual humiliation increased the stress and risk of both family and child. However, access to knowledge

and confidence gained through engaging in the research process and developing their group consciousness, enabled the parents to challenge this process and at varying levels to develop the confidence to work with the school as an advocate for their child.

The above three risk factors identified by the parents have not been isolated in the literature on risk and resilience in CAMH using quantitative techniques of regression analysis (Rae Grant et al 1989, Rae grant 1994, Pearce 1993, Haggerty et al 1996).

Furthermore, they are not included in the parenting literature on the specific challenges faced by parents of children with challenging behaviours (Cunningham et al 1995, Webster Stratton 1991 and 1998). Using the qualitative approach adopted here, the parents illustrated how these factors have a very real effect on their everyday lives and their capacity to care for these challenging children. These risk factors are recognised in the broader social policy literature (Pond and Popay 1983, Lupton 2003, Carley 1990) However, in the social policy literature they are applied to general populations rather than to the specific population using CAMH services.

Consequently, they have not been isolated as important factors to be considered when developing services for these children using the quantitative and experimental research techniques, which inform the evidence base for CAMH practice. This highlights a potential gap in the evidence base for CAMH practice and the importance of addressing these factors in order to enable parents to care effectively for children with challenging behaviours.

Similarly, the importance of including lay perspectives and voices in the development of social policy has also been identified (DoH and DfES 2004). For instance a

national survey of the perceived needs of disadvantaged parents undertaken by Ghates and Hazel (2004), described in more detail in chapter two, identified that the level of support the parents perceived they had from both formal and informal sources varied: 47% of parents considered that they would benefit from more support with bringing up children and 11% said they often wished for more help (Ghates and Hazel 2004). Parents who felt unsupported were less likely to feel they were coping. Paradoxically, parents who felt unsupported were also those most likely to be receiving higher levels of actual support from informal and formal services. The paradoxical findings of Ghates and Hazel (2004) may indicate that parents may indeed be receiving what is offered to them formally or informally, but that this is not meeting their needs. A specific recommendation of Ghates and Hazel study (2004) study, which resonates with the recommendations of the parents in this thesis, was:

‘Family support services need to pay more attention to parent’s perception of the support they provide in terms of how useful and appropriate it is felt to be. Assessing needs in partnership with parents by asking them what they themselves think would be a good place to start’. (Ghates and Hazel 2004, p. 20)

A further recommendation of the Ghates and Hazel (2004) study is:

‘Services and professional support staff need to find ways to demonstrate respect for parents’ own expertise in their own lives. Parents most certainly welcome help and support, but not at the cost of their own autonomy. Training in listening and engaging seriously with parents’ own concerns and negotiating in partnership with them about

the best course of action may be needed for health and social care workers to work with families' (Ghates and Hazel 2004, p.23).

The key ways of supporting parents, which emerged from the Ghates and Hazel (2004) consultation study with parents were: to provide a diverse range of both formal and informal support; to help parents gain a better understanding of what is available; to build on parents' strengths as well as their weaknesses; to recognise when parents perceive that support is helpful and when they perceive it is interfering and to enable parents to feel in control. This thesis identifies practice knowledge and methodology, which can provide one way of operationalising this in a community context with parents.

Although the Ghates and Hazel study (2004) does not focus specifically on working with parents whose children have challenging behaviours, it identifies a clear gap in the service support experienced by parents in the study and a clear indication that parents would like to receive services that value and maintain their autonomy. Again, the theme of service and practice recognition of strengths and stressors at an individual, family and community level resonates with the findings of this thesis and the proposed practice theoretical model. Again the findings and analysis of this thesis provide an empirical example of how to translate and refine information from the survey of Ghates and Hazel thesis through application to practice and subsequent development.

The literature on including the perspectives of disadvantaged members of the community on service provision has, therefore, tended to adopt a consultative

approach with a general population. The opportunity of using clinical practice as a medium for accessing parental perspectives on service delivery and using this as evidence for practice as illustrated in Fig 5b described above has not been fully developed and this thesis can provide a platform to build upon.

Action plan emerging from this thesis

Reed (2004) has highlighted the limitations to action research, which does not address the processes by which the knowledge developed through action research can be owned and advanced by practitioners and service users. This emphasises the importance in practitioner action research of developing a way forward in practice. The key practice and research outcome to this study is the development of a practice action plan which provides a way forward by synthesising the thesis findings and analysis with the theoretical, empirical and philosophical literature to produce a framework that incorporates the values of critical care and emancipatory CAMH nursing practice. From a practice research perspective, the need to build bridges between these different methodological and philosophical worlds to enable very different ways or cultures of knowing to evolve was discussed in chapter three. Here the work of Schein (2001, p.8) and Miller and Crabtree (2000) was used to demonstrate the limitations for clinical practice knowledge in health care of adopting singular perspectives grounded in distinct research or philosophical traditions. Instead the case was made for developing approaches to research which draw on the strengths of the different research traditions in nursing and health care in order to provide an adequate evidence base for practice. As discussed by Falk-Rafael (2005), and supported by the findings of this thesis, this means combining the research on healing from psychology and psychiatry and the medical model with knowledge on

oppression and injustice from critical theory and the social model of health, so that the nursing roles of professional carer/helper and emancipatory change agent are incorporated.

The practice framework (see Appendix 2), that emerges from this research thus attempts to synthesise the parents' findings, the analysis of these findings given in this and the previous chapter with the theoretical model described in Fig 5b above, into a collaborative process, which applies the key practice and emancipatory principles that have emerged from the participative action research with the parents:

- (1) Parents should be partners in the creation of CAMH knowledge and the development of services
- (2) Parents should have professional and published child and adolescent mental health knowledge shared with them in a user-friendly process. This thesis has identified a range of empirically derived evidence, which is potentially useful to parents of children with challenging behaviours in terms of helping parents to understand their child and respond to their particular needs. This includes literature on temperament, attachment, ambivalence, information processing and on risk and resilience. The practice framework encourages practitioners to use their knowledge of the context and client to translate this knowledge in a user friendly way. The information and format in the framework provides a guide to support this process.
- (3) Parents need to be supported to engage in a critique of current service delivery and the research underpinning it in order to understand and critique how CAMH problems are defined and maintained.

- (4) In order to maximise their capacity to respond to CAMH needs, parents should have their strengths acknowledged and promoted and their needs identified and responded to at an individual, family and community level.
- (5) Parents require a proactive response to their total set of needs and those of their children rather than a reactive service response. This requires planning for continuity of support according to need by using the total resources in their extant systems (including services such as recreation and childcare) rather than episodic specialist CAMH care triggered by crisis episodes.
- (6) Parents and professionals need to develop meaningful partnerships with the wide range of service providers in which they have a dialogue and a reciprocal exchange of information
- (7) Parents need to be empowered to be creators and not just passive users of services e.g. to identify and question rather than passively accept the gaps between service provision and needs. This means that explicit mechanisms need to be in place for feeding this back to providers and policy makers, who influence the systems used by the child and family.

TABLE 11. Format of Practice Framework (Appendix 2) that has emerged from findings and analysis within this thesis

Section 1

In section 1, the framework feeds back to the parents the findings from this thesis and seeks their permission and commitment from them to engage in further iterative development and analysis. In this way, the parents are invited to engage with the PF and the iterative process continues in which parents become creators of knowledge.

Section 2

In section 2 of the framework, information, which parents in this thesis found useful, is explicitly shared with parents. Information on risk and resilience is shared in order to develop an individual understanding and systemic analysis of the child's needs. Further information, which the parents in this thesis found useful, is also shared including information processing (section 2.1.1.) relationships/attachment section (Section 2.1.2.), and temperament (section 2.1.4.) In order to help the parents understand the CAMH system, the professional definitions of problem and disorder along with the likelihood that the child may meet the definitions of disorder, are included for discussion with parents in section 2.1.5.

Section 3 and 4

Section 3 of the framework explores the systemic strengths and needs of the family while section 4 explores the strengths and needs of the community systems with which the child and family interact.

Section 5

Section 5 facilitates joint planning with parents and provides the opportunity to discuss with parents a range of options, the resources available locally and to identify any service gaps.

Section 6

The parents are explicit partners in the evaluation in section 6

Section 7

Following completion, the parents engage in a joint discussion to plan how they can continue to develop their strengths and reduce their needs and when to seek further services

The aim of the Practice Framework or PF (Appendix Two) is that it is used within a collaborative and emancipatory process between the professional and the parent(s). Because of this, it is designed as a cognitive map rather than a prescriptive manual, to guide the professional to systematically operationalise the above principles in order to work collaboratively with parents. It is anticipated that the practitioner will simultaneously adapt the language and format of the PF to the needs and context of the parents. The format of the PF provides scope for practitioners to continue to iteratively modify the framework in response to further insights and refinements provided by parents and practice experiences. The aim of the PF is to facilitate a negotiated agreement with the parents on their needs and ways of meeting them through a mutually signed contract. It therefore explicitly conveys a message of joint accountability for supporting children with challenging behaviour and their families. The format of the framework is described in Box One.

The Practice Framework attempts to facilitate a change process, which can break the hegemony of professional knowledge by creating a reciprocal learning cycle. This can maximise the capacity of the parents by providing parents with access to medical, psychological, social and emancipatory health literature and by giving them a voice and an opportunity to inform professionals and influence service provision.

Although the parental theory and the practice framework are grounded in the experiences of the parents in this study, it could be argued to have a high likelihood of also being applicable to a wider range of parents for a number of reasons. Firstly, it incorporates the information, which the parents found useful such as information on temperament traits, which are normatively distributed (Chess and Thomas 1996).

Secondly, the Practice Framework develops an individualised profile of the child, family and community risk and protective factors (derived from an analysis of both CAMH literature on risk and resilience and the emerging findings and analysis form this thesis). This can be used as a tool to proactively listen and respond to a wider population of families , where there are CAMH issues as all families have strengths and needs.

Thirdly, the framework involves active collaboration with families to find individually and culturally acceptable ways of meeting needs in ways, which are feasible in their local context.

However, the framework needs to be iteratively tested out, refined and modified with a wider population of parents to explore to what extent it can in fact be utilised as a way of engaging in reciprocal information exchange and in the development of the local service capacity to respond to children with behavioural problems. Further work is also required to discover if the Practice Framework can be an agent of change in developing services which are proactively responsive to the child and family needs within their 24 hour context.

Critical discussion of the proposed action plan and implications for future development

The last section of this chapter provides a critical discussion of the proposed action plan from both a theoretical and practice based perspective. In discussing the macro issues and broader complex problems associated with the development and implementation of the action plan, there is no intention, nor is it possible in a thesis such as this to develop the 'grand solution'. Rather, the intention is to highlight the

issues raised by the development of a Practice Framework that conforms to the critical principles underpinning action research and which must be confronted and debated in order to develop nursing practice with parents in what is acknowledged will be an iterative, evolving, long term process.

Critical theory as defined by Horkheimer (1972) recognises that it is necessary to assess society's potential for emancipatory change and engage in a critique of the system to create the conditions necessary for change. If this is the case, it follows that these processes are equally crucial in assessing and developing nursing and health service potential for emancipatory change. Emancipatory nursing development must identify the broader social conditions, which are necessary to implement the action plan and optimise the change and transformation process. This includes acknowledging and confronting the potential obstacles/constraints, which could limit the potential for change and transformation. If left unexplored, these could set both the nurses and parents up for failure and disappointment. There is therefore an ethical issue associated with attempting to achieve emancipatory change in nursing practice, which requires a critical analysis of any emergent action plan (such as that discussed above) and the capacity of the system to engage in change.

Professional Power

The thesis has illustrated the potential for professionals to consciously or unconsciously oppress their clients. This oppression can be legitimised in a number of ways. According to Turner (1995, p.130) professional status is legitimised through displays of altruism, professional competence, social responsibility, the possession of specialist theoretical knowledge, socialised training with formal examinations and a professional body.

Larson (1980) argues that the status and power of professionals depends on their ability to maintain 'social closure' based on specialist knowledge and a university qualification. The parents in this thesis illustrated their initial difficulties in challenging the knowledge and ideas of professionals with 'legitimated qualifications'. However, supporting parents to democratically access literature and to critique legitimated knowledge, as proposed in this thesis could be perceived as a threat to the social closure established by professionals, who could potentially act defensively to counteract this threat.

It is also recognised that the social belief that professionals act altruistically out of a sense of vocation can serve to protect them from scrutiny (MacDonald 1998). By questioning the status quo, parents may also threaten the power invested in the social belief that professional act altruistically. Burman (1997) discusses that this critique is necessary as power is invested in the positions that people occupy and argues that professionals replicate hierarchies of knowledge and power that place them in the position of 'agents who know better'. However, Oppenheimer (1973) and Turner (1995) both suggest that in contemporary society, there is a widespread process of de-professionalisation or proletarianisation of professionals, which can occur through the growth of bureaucracies, the socialisation and development of knowledge which can fragment professionals into separate groups and 'mechanise' their work as well as pressure from new professionals to encroach on the domain of the most established and prestigious professionals.

Johnson (1995) discusses how most of the sociological literature on the professions is hindered in its theoretical development by a 'misconception of the relationship between the professions and the state' (Johnson: 7) in which any interference by the state in professional conduct is interpreted as a threat to professional autonomy, which will weaken the profession. Johnson (1995) is sceptical about this relationship arguing that rather than a duality between state and professions, professional autonomy, power and independence is a product of an inter-dependent relationship. Professions, he suggests are granted autonomy, power and independence over the technical and expert aspects of their work by the state, only so long as they carry out necessary functions of the state. They are by no means independent; instead the expertise of the professions forms an important part of the apparatus of the state enabling key functions of government to be achieved. If this is the case, it is important to understand professional sensitivities about their role and function and the limitations of the control they exercise over their expertise in order to develop insight into the opportunities and constraints for social change

Turner (1995, p.109) discusses how professionals are characterised by a duality between technical and routine knowledge and the "ideology or mystique of interpretation". Freire (1985, 1998) proposes that the apparent underlying belief in objectivity provides scientists with a mask of positivism and empiricism that can be used as an excuse to ignore social and political practices, which are oppressive and to underpin the practice of dismissing oppressed minorities as legitimate subjects of research.

The findings from this thesis start to provide evidence of the value of critical caring practices in making a therapeutic contribution to health care alongside other therapeutic interventions. Feminist writers such as Ehrenreich and English (1978) argue that women cheapen the costs of labour. The parents (all mothers in the study) illustrated how they were doing the bulk of care and containment with the least resources, support or recognition. Riska and Wegar (1993) describe how women continue to function in the health system as subordinate labour. Davies (1992) has developed the concept of organisational neglect to explain the status differential in the knowledge ascribed to nurses and other carers when compared with the more episodic contributions of more high status health care professionals such as Doctors and Psychiatrists. Davies (1995) argues that organisational neglect gives rise to behaviours, by those experiencing neglect, which are frequently viewed as dysfunctional and ineffective by more high status professionals, reinforcing the lower status of caring professionals. As discussed by Rolfe (1998) nurses and other professionals engaged in caring practices have had to adopt more traditional approaches to science and practice in order to gain status and thus have been forced to move away from meeting care needs.

The findings in this thesis indicate that carers were the least likely to have the power to define behavioural norms or have access to knowledge and the most likely to be blamed/penalised for deviation from the norms, while their behaviours were frequently judged pejoratively by those with more power and status. This finding is characteristic of the process of organisational neglect described by Davies (1995). This thesis highlights therefore the need to analyse the organisational perspective and

the roles of professionals (Schein 1987, 2001), as discussed in chapter three, in order to maximise the opportunity for emancipatory practice change.

Using practice to achieve change

Falk-Rafael (2005) has developed the concept of critical caring to identify how the use of empowerment approaches in nursing can bring about change in population health at a community level.

The findings from this thesis indicate that it is possible for practitioners, using participative collaborative practices, to achieve change at a local level e.g. the parents became skilled at challenging the beliefs held by the schools which their children attended.

Future Research

The concept of continual revision of the practice framework through practice use is in keeping with the basic tenets of practitioner research (Brooker and McPherson 1999, Stenhouse 1981). Practitioner research places great emphasis on deriving knowledge for practice from what we can learn through practice (Rolfe 1998a, 1998b). Fals Borda (2001:30) describes how the work of Bacon in 1607 in his booklet on 'Thoughts and Conclusions' discussed the theoretical tensions created by direct action and the primacy of the practical. Bacon wrote 'In natural philosophy, practical results are not only a way to improve conditions but also a guarantee for truth. Science must be recognised by its works. Truth is revealed and established through the testimony of actions rather than through logic or even observation'.

The importance of the primacy of action is increasingly being recognised and theorised by a range of researchers (Rolfe 1998a and 1998b, Higgs et al 2004). Here

the importance of developing and acknowledging the complex and sophisticated skills used by nurses to accomplish practice is recognised. It is hoped that the methods used in this thesis, the findings and the emerging analytical framework can contribute to this growing body of literature. In particular the thesis highlights the importance of paying attention to professional hegemony over knowledge and the idealisation and simultaneous appropriation of sophisticated caring skills and knowledge and to the detriment of service users that this hegemony can engender. In this context, Reed (2004) has identified the need for action researchers to address issues of the ownership of knowledge if the knowledge produced is to contribute to the body of knowledge for nursing practice rather than remain at the level of abstract academic debate. Reason (2003) has identified the need for action researchers to find new language to describe their work, rather than be caught in the dualist academic metaphors of research. Nurses developing knowledge based on the primacy of action need to be alert to these concerns if they are not to use these methods as a means to maintaining professionalisation rather than improving patient/client care.

The argument that knowledge should be used to improve practice may potentially provide a dialectic for resolving the tension between theory and action. Fals Borda (2001) proposed that it is necessary to bring about a convergence between popular thought and academic science, in order to gain a more complete and applicable knowledge especially by and for the underprivileged classes who are in need of scientific support. Practitioner research as illustrated in this thesis provides a potential way forward by realigning the methodologies in order to develop a cumulative and emancipatory practice knowledge base. Through the methods described in this thesis it is possible to demonstrate a way for practitioner researchers, who adopt critical

theory, to both identify the parameters of positivist knowledge and to demonstrate respect for professionals, who employ a predominantly positivist knowledge base, by acknowledging that although the ontological assumption that the positivist research produces 'truth' is questioned by critical theory, the positivist knowledge base has a value to practitioners and a role for practitioner researchers and carers as a tool to interrogate practice and to facilitate the articulation of their previously tacit skills and knowledge. However, the cumulative knowledge base arising from this is not regarded as absolute truth and therefore there must be a commitment to an iterative process of refinement and development of practice knowledge.

The findings from this thesis do not, therefore, reject the value of knowledge derived from positivist approaches to science but suggest that it be used not as a generalisable knowledge, but generative knowledge. This provides a dialectic way forward in which professional skills and knowledge, derived from a diverse range of sources, are maximised in an emancipatory rather than an oppressive way. Gaining more knowledge about the lived experiences of parents may actually help professionals to refine and develop their professional contribution, by engaging in a critical analysis of both specialist knowledge derived from traditional research and also participative research with parents, within an emancipatory approach, which transparently serves to meet the clients' needs. Engaging in participative research with parents can thus help professionals to be actively accountable in incorporating the professional values related to respect and democracy and can therefore be seen as a way of helping professionals to meet their vocational goals and to adhere to clinical governance guidelines by including the 'user voice' (DoH and DfES2004), whilst simultaneously engaging in an emancipatory collaborations with clients.

It follows from this analysis that practice science is validated by exploring effectiveness in everyday practice, which becomes a key issue for future research (Reason 2003). This will require a sophisticated methodology in which positivist and participative methods work together to develop a cumulative knowledge base. A key question for future research therefore is how to define 'effectiveness' and then ask 'what works for whom, in what kind of context?' (Pawson et al 2004). It is increasingly apparent that in order to incorporate the reality of complex contexts and systems, that this will require positivistic and qualitative, exploratory and participative research (Pawson et al 2004).

Findings from the participant research methodology used in this thesis could also be used to develop further quantitative research. For instance, the theoretical proposition of the development of systemic capacity described earlier in this Chapter could be developed into a clinical trial.

Factors such as dissemination of knowledge, using a group to raise consciousness, reducing isolation and oppression, have all been identified by parents in this thesis as crucial success factors in helping them to develop their capacity and resilience. In the future, techniques of logistic regression could be used to test out the effects of these factors on much larger population groups by combining data on group processes and outcomes from a large number of parenting groups. Future quantitative research could explore the relative impact of these effects and thus contribute to planning effective interventions, which are underpinned by collaborative, participant action research

with clients. If the products of participative action research are effective, then it should be possible to measure the effects at an aggregate level.

Summary and Conclusion

This chapter started by using a well established dichotomy between the medical model and the social model of health (Seedhouse 1986, Locker 1997) to analyse the experiences of the parents reported in this thesis. The findings indicated that despite contemporary government policies advocating the social model of health (Health Advisory Service 1995; Department of Health 2004), the parents' experiences were dominated by an interpretation of health that conformed to the medical model. The analysis demonstrates the limitations for parents of working within either model to the exclusion of the alternative model. The introduction of critical theory into the practice of nursing during the course of this research, indicates how at a practice level nurses and other health care professionals may be able to break out of the constraints imposed by adopting one model at the expense of the other, and develop innovative ways of working which start to integrate these two models. The need to move beyond the dualisms which frequently define academic work and develop a new language of inquiry has been discussed by Miller and Crabtree (2000) and Reason (2003). As Falk-Rafael (2005) recognises in nursing, this requires the development of the concept of critical caring if we are to integrate public health nursing practice, which adopts a social model of health into an expanded nursing caring science that incorporates the social justice agenda.

Chapter 9

Reflections on my practice and theoretical development as a result of engaging in this practice research with parents and conclusion.

Flick et al (2004) identify that one of the key characteristics of qualitative research is the role of the researcher, who is important because the researcher is the tool or instrument of data collection. It is through them that data is gathered, analysed, interpreted and disseminated. It is important therefore, as Coffey (1999) points out, for the qualitative researcher to write themselves into the research. As this thesis is underpinned by practitioner research and critical theory, this chapter will explore how I have changed and developed as a practitioner and practitioner researcher as a result of engaging in this thesis. It will, therefore, analyse the change in my own practice knowledge and theory and locate this in a discussion of the ways of knowing arising from praxis-practitioner research and critical theory, which were discussed in the previous chapter.

Refelctions on the role of Nursing in emancipatory Practice

There is a huge theoretical literature in nursing which has attempted to clarify the role of nursing in health care. Until quite recently much of this literature was developed into nursing models and theories (Aggleton and Chalmers 1986, Leddy and Pepper 1993, Fawcett et al 2001). Like many nurse theorists, Parse (1999) asserts that the focus of nursing is the health of persons in interaction with the environment. She defines health as expanding consciousness in which the pattern of openness, diversity

and quality of persons interacting with the environment are increased. Thus conditions of freedom and unrestricted choice are essential for health, according to Parse, because they allow for expansion of an individual's potential and an increase in consciousness about their situation in their world (Parse 1999).

Parse's perspective is reflective of a wide range of theory and literature in nursing. Leddy and Pepper (1993) distinguish between nursing models designed to re-establish health stability following the onset of a health crisis and nursing models which interpret health as a continuous process of growth and accommodation to dynamic changes in the internal and external environment. Benner and Wrubel (1989) focus on the primacy of caring as a foundation for human health and development and the realisation of human potential. Fawcett et al (2001) review a variety of nursing models, which all seek to locate the primacy of nursing care in promoting health and maintaining the person through illness and possibly death. Parallels can be drawn between the emancipatory elements found in some nursing models such as that proposed by Parse (1999) and the basic assumptions of critical social theory, which maintain that liberation from oppressive structures is a crucial condition in the quest for realising human potential. Fleming and Moloney (1996) discuss the importance for nurses of developing emancipatory knowledge, which 'arises from an emancipatory interest in rational autonomy and freedom and is socially reflective, taking the form of a critique of socially imposed constraints' (Fleming and Moloney 1996, p.118). Engaging in critical theory in this thesis has helped me as a nurse to understand the factors which affect and constrain people's health and has provided a way to work with parents, as clients to transform conditions. This has helped me to develop an insight into how the application of critical theory, as discussed by Falk-

Rafael (2005) can help to develop nursing practice and guide emancipatory nursing research.

Emancipatory theories of health and nursing (Parse 1999, Fleming and Moloney 1996) assume that the more accurately and extensively individuals are able to perceive and reflect upon the socio-political and psychosocial environment, the more effective they can become in using their environment to develop their health. This was illustrated by the parents in this thesis, who demonstrated that access to literature and the application of critical theory by the facilitators with the parents could be instrumental in enabling the parent's to develop critical awareness of the socio-political context of child care and to articulate their tacit knowledge of the importance of taking a holistic and total systems approach, when caring for children with disruptive behaviour problems, as discussed in the previous chapter. This thesis has thus provided a practice demonstration of how working with parents in ways, which encourage them to explore 'what could be' (Thomas 1993) and not 'what is' can empower them to be aware of the potential oppression in their lives as well as signposting the opportunities to gain control, through the access, critique and application of legitimate knowledge.

More recent developments in nursing theory are recognising the importance of adopting a critical social theory perspective. Fontana (2004) has identified the contribution this approach can make to developing nursing practice knowledge. Falk-Rafael (2005) has developed the concept of critical caring that she suggests provides a stabilising reference point, against which nurses can critically examine, new and emerging social policies. She argues that because caring cannot occur outside of a

relationship, approaches to population health which rely solely on epidemiological evidence, used to inform the social model of health, fail to provide nursing with an adequate evidence base for relationship focused practice, because the health of communities is inextricably linked to the health of its constituent members' health and therefore experiences are located in individual and family members comprising that population. The development of critical caring practices, which include emancipatory and empowering techniques provide nurses with a way of relating individual experience to the wider community of which these individuals are a part.

As discussed earlier, the social model of health derives primarily from epidemiological evidence on whole populations, while the medical model of health derives its evidence predominantly from the effectiveness of interventions on improving health outcomes for individuals. Early nurse theorists such as Newman (1986) and Leddy and Pepper (1993) recognised the impact of environment and context on health outcomes, but did not really incorporate the epidemiological evidence underpinning the social model of health into their theories and descriptions of nursing practice. The more recent developments in nursing theory using a critical and emancipatory approach (Fleming et al 1996, Fontana 2004, Falk-Rafael 2005) are starting to identify how this long established dichotomy, between the medical and social model of health, might be addressed in practice.

When I started work on the thesis, I had worked in CAMH for 23 years and during this time worked as a senior nurse in an in-patient and out-patient setting of a regional CAMH service, an academic in CAMH at a university and as a CAMH advisor to the Department of Health in London. During this time, my understanding of the role of

parents in caring for children with challenging behaviours developed along with a growing insight into the importance of services working in partnership with parents. However, engaging in this thesis and using a participative practitioner research approach in partnership with parents who are also clients in the CAMH system (because they have sought help for their children with significant challenging behaviours), has helped me to develop because I have had to engage in more sophisticated and complex processes than I had previously encountered either in my practitioner or in my researcher role in which I undertook, for example, the research with fellow nurse practitioners that this thesis builds on. It has also highlighted to me that there is as yet a dearth of analysis of this complexity in current literature.

The complexity that I experienced in undertaking this research meant that I had to constantly critique, refine and develop established research methods in order to make them fit the ethical integrity and practical reality of the clinical research setting. This required that I explore with parents how relevant they find scientific/nursing knowledge, address how to develop new practice knowledge and insights arising during the course of providing a service to parents and avoid using the data merely as a means of contributing to the published literature. It was important, therefore, to identify how to influence and change practice locally, in a way that encompasses the key messages brought to the research by the parents and to operationalised this into an action plan. Crucially, because of the potential power inequities between me as the practitioner and the parents as clients it was important to use methods which located the research within an emancipatory framework.

Reflections on Practitioner Research

There is a range of literature which supports the practitioner research approach used in this research, but it tends to refer to research with fellow professionals rather than with clients to whom a service is simultaneously being offered. However, building on previous practice research has been essential to developing the methods in this thesis. Rolfe (1998a, 1998b and 2001) has written extensively about the development of practice through practitioner centred research. He suggests that 'practitioner research can be of three kinds... replicative, reflective and reflexive research' (Rolfe 1998a, p. 92). This thesis, however, has required a synthesis of all three.

Replicative research tests out the findings from generalisable scientific studies in the practitioner researcher's own area and also attempts to verify the personal theories derived from his/her personal and experiential knowledge. The aim of replicative research is not to replicate the methods of the original study, but to replicate the findings in the practitioner researcher's own clinical setting (Rolfe 1998a). In analysing the propositions from the previous nursing study (discussed in chapter 5), that were derived from a diverse range of sources of evidence, including scientific and experiential evidence, this thesis has engaged in replicative research. Similarly, the method of inductive analysis of published literature used with the nurses was transferred to this study to help the parents interrogate the findings from the nursing study in the light of their experiences.

The principles of critical incident analysis were helpful when working with parents in a situation of potential power inequity as it gave parents a method for challenging the nursing propositions while maintaining their own integrity through their own stories

and experiences. However, this would not have been sufficient on its own to achieve the practitioner aims outlined in this thesis, which involved participative work with parents in order to explore the impact of utilising parental knowledge to increase the systemic capacity to care for children with challenging behaviours.

According to Rolfe (1998a) reflective research generates personal and experiential knowledge and theory from the practitioner's own practice. The aim is not merely to replicate existing findings for their validity in the specific practice context, but to create new knowledge and theory through a formalised approach to reflection on action. Diary keeping and critical incident analysis are useful methods for this approach (Rolfe 1998a). Application of critical incident analysis principles and the use of field notes were helpful in this thesis in generating theoretical understanding about practice knowledge. However, this thesis was not just about generating the personal knowledge and experiences of the practitioner, but was also about exploring how to achieve development of both practitioner and client knowledge through reciprocal exchange of their respective knowledge and experiences.

Reflexive research, the third form of practitioner research identified by Rolfe (1998a), attempts to bring about an integration of practice and research in a single act. The aim is not only the generation of knowledge, but also the implementation of clinical change directly through the research process itself. Action research is a classical method for this approach (Rolfe 1998). In this case the thesis has focused on creating change in which the client is a participant.

Although Rolfe (1998a) identifies that practice-centred researchers can take any one of the above approaches, the findings from this research indicate that it is important when researching with clients as research participants to consider combining all three approaches because delivering a service and simultaneously researching it is too complex for any one of these approaches on their own. However, even the combination of all of these approaches does not deal adequately with the potential power inequities between a nurse with a legitimated professional qualification and a client, particularly the parents in this thesis who were disadvantaged at a socio-economic level and emotionally vulnerable because of the sense of guilt, failure and helplessness they experienced. Exploring the oppression experienced by parents and supporting parents to interrogate this by asking them to reflect on what could be rather than what is, as advocated in social critical theory, has been a helpful technique in addressing power inequalities embedded in the practitioner researcher/client relationship central to this thesis.

Exploring the parents' experiences by using a diverse literature enabled an integration of the three types of practitioner research described by Rolfe (1998) above, with an emancipatory approach (Fontana 2004, Khanlou and Peter 2004) as it enabled a process of conscientising (Freire 1999) parents to the opportunities for developing a sense of control over their lives and the care of their children. This emancipatory approach supported the parents to critique the tacit assumptions and beliefs, embedded in the professional and societal literature which appeared to constrain parents from maximising their capacity to develop the holistic sense of health, discussed by Parse (1981, 1999), because the professional literature did not address how to improve care in a 24 hour context. This thesis indicates that it is by addressing

the care undertaken by parents in a 24 hour context that it is possible to gain a greater understanding of their own contribution and worth.

Reflections on the use of Critical Social Theory in Nursing Practice Research

Fontana (2004) proposes that 'Critical science in nursing is often connected philosophically and methodologically with the work of Paulo Freire, the Brazilian educator best known for his book 'Pedagogy of the Oppressed' (Freire 1999). Freire (1999) followed a Marxist tradition, believing that people must emancipate themselves and overcome the false consciousness caused by oppression. In his theory of emancipatory education, Freire (1999) discussed liberation as a process of dialogue, problematisation and increasing critical consciousness or conscientisation. The thesis has helped me as a nurse to find ways of operationalising this type of Freirean liberation in the field of CAMH. On reflection, it is significant that in my earlier CAMH study with nurses (Croom 1996) and in the various senior positions I have held as a senior practitioner in CAMH prior to undertaking the research, that I have not previously been required, by the ethical integrity of the situation, to engage in this debate.

Engaging in critical theory and participatory research with parents has helped me as a nurse researcher/practitioner to develop insight into the complexity of operationalising emancipatory nursing research in CAMH with parents, who are both research participants as well as clients. In doing so, I have had to confront the practice and theoretical debates, which emerge when carers access and critique professional nursing knowledge as participants in practice research. I have found that it is possible to develop and refine practice knowledge through engaging in a rigorous

and systematic exploration of the kinds of knowledge and skills, which can support carers/clients to develop as carers and which can support professionals (in this case nurses) to develop knowledge on the psychosocial variables which are essential to support clients/carers to access professional knowledge and to critically apply this knowledge to their context. As a practitioner researcher, I have thus learned the critical importance of articulating and synthesising different types of knowledge in order to develop a holistic understanding of complex practice situations. I have also learned the vital importance of working in collaboration with parents to synthesise a diverse range of knowledge by using the contribution to the practice of caring as the organising framework for the synthesis of this knowledge. This has perhaps been the most difficult aspect of the thesis and the most difficult to explain and justify as most approaches to the synthesis of knowledge and literature use abstraction or critique as organising factors rather than praxis. Much more work on eliciting the principles of undertaking this type of literature synthesis is required.

Reflections on the types of knowing arising from this research

According to Carper (1978, p.20), 'personal knowledge promotes wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment and this requires knowing, encountering and articulating the concrete individual self. This kind of knowing demands of the clinician the involvement or engagement of the whole person, including thinking, sensing and perceiving skills. It is the outcome of both professional and personal experiences and crises accompanied by reflection. Personal knowing can thus be argued to be a fundamental outcome of care of an individual (or in the case of this thesis a parent or child). Engaging with the parents as both clients and fellow researchers demanded my total emotional,

cognitive, social and intellectual involvement. However, the nursing literature such as that of Carper (1978) and Higgs and Titchen (1995) discuss knowledge and knowledge development in relation to professional/clinical development, rather than the emancipatory client-centred approach undertaken in this research.

Reflections on my learning as a practitioner researcher from the methodological issues identified in this research

Professional research has produced a wealth of propositional knowledge derived from literature, on working with parents in CAMH (Cunningham et al 1995; Webster Stratton 1998) which is reviewed in chapter two. Similarly, there is a plethora of nursing practice research which relates to experiential knowledge (Rolfe 1998a; McCormack 2003). Although this is much more limited in CAMH, there is a growing literature on discovering clients' views through focus groups and consultations conducted by professional researchers (Heyman 1995; Ghates and Hazel 2004). However, nursing research does not yet seem to have fully embraced the complex theoretical debates, which are necessary to develop and refine practice knowledge using a critique of professional knowledge and skills (from a diverse range of sources) undertaken with clients/carers.

In the course of this thesis, I have not been able to find any one single methodological approach, which could deal with all of the issues raised. A combination of approaches was required.

The first methodological issue to be addressed involved recognising and acknowledging the tacit knowledge of parents. At the start of the research I had to make an assumption that parents had developed their own set of knowledge, skills and

expertise to care for their child in their family context. This assumption drove the research and dictated the methods used. The thesis findings indicated that parents seemed to have developed tacit knowledge, which could be both helpful and unhelpful to them, when caring for their child e.g. some parents could instinctively tune into their child's needs, but other parents/or parents at other times, attempted to make sense of the child's challenging behaviour, through the use of tacit attributions about the intent of their child's behaviour e.g. that the child loved to deliberately 'wind up' their parent.

However, the parents set of knowledge and skills and attributions (both helpful and unhelpful to the care of the child) tended to remain at a tacit and intuitive level, which the parents found difficult to articulate and therefore to either critique or build upon. In order to surface this intuitive but influential knowledge and interpretations of their child's behaviour, a critical heuristic devise was required to provide a language and framework to interrogate the parents' taken for granted knowledge and experiences. The Nursing Practice Framework produced by nurses (appendix 1) involved in 24 hour residential care helped to provide this.

The second methodological issue to be confronted was how to create a dialogue on the transferability of nursing skills to the parent's context in the community. In attempting to discover how relevant the Nursing Practice Framework was to parents, it was essential to access authentic experiences of caring for children with challenging behaviours in the parent's everyday lives. Using the Nursing Practice Framework (appendix 1) to interrogate everyday incidents from the parents lives helped to create

a dialogue on how/whether access to nursing knowledge can support parents to care for their children with challenging behaviours.

Critical incident technique (Smith and Russell 1991) provided a useful heuristic for achieving this, because it helped parents to produce authentic data and examples from their everyday lives. Using the critical incidents as a tool to engage in reflective action cycles seemed to provide a way for both nurses as facilitators and also parents to engage in reflection in and on action and so seemed to reflect a true partnership.

However, the work of Freire (1993, 1998) and Scott (1986 and 1990) and Gaventa and Cornwall (2001) helped me to develop insight into how potential power inequity between the parents and the nurses, acting as the practitioner researcher and the group facilitator, could remain a methodological problem, because of the tendency of relatively powerless groups to either echo the voice of the powerful or comply with more powerful parties because of the internalisation of dominant views and values. This tendency could have provoked the parents to agree with nurses or report what they felt the facilitators wanted to hear.

Engaging the parents as researchers in a group setting as opposed to individual interviews appeared to help the parents to construct their own knowledge and develop the conscientisation advocated by Freire (1998), which enabled them to challenge us as nurses/group facilitators and the professional viewpoint in general. Using the group to negotiate a joint understanding that the parents were being asked to inductively analyse the framework for whether it was useful or not, seemed to be helpful in developing a process through which the parents were explicitly given permission to be critical and therefore could engage in this debate. However, critical

learning for me as a nurse/CAMH professional arose from realising that despite my considerable experience and education in CAMH, I had not been previously educated, socialised or 'conscientised' to the potential oppression experienced by parents and their children, who have challenging behaviours. This was illustrated by the experiences recounted in the critical incidents and reflective action cycles, in which there was a common and unanimous emergent theme of guilt among the parents arising from their perceived sense of failure and inadequacy as a parent, across each of the eight cohorts. In learning how to act as an emancipatory practitioner/researcher, I also had to learn to deal with the negative feelings which were temporarily directed at us as group facilitators, when the parents began to develop the confidence to challenge the status quo. As group facilitators, we learned to anticipate and to actually celebrate this process in each cohort as a sign that the parents had used the group to develop conscientisation and became sufficiently empowered to challenge us.

In order to achieve this conscientisation (Freire 1993 and 1998) however, a common finding across each cohort was that parents needed to feel safe and confident within the group to overcome the difficult feelings that had been induced in them prior to the research. This represented important practice knowledge for nurses working with vulnerable groups of parents. Using the critical incident technique to give a message that the parents' views and experiences are important and acknowledging the parents' own needs for nurture if they were to be emotionally available to their own children, appeared to be critical aspect of nursing practice used in executing this research. I found that an observable criterion for the parents having achieved this was that not only did they begin to challenge the facilitators but they also began to interact more

among themselves rather than through/with the facilitators and also to reference their own knowledge and skills arising from their own learning rather than that of the facilitators. Encouraging the parents to access the nursing framework and any other literature that appeared to be relevant to their experiences such risk and resilience (discussed in chapter 2 and chapter 8) appeared to help parents to develop a greater sense of control in their lives, which enabled them to be better advocates for their child e.g. by negotiating a joint understanding of the children's needs and care with the child's school teacher.

However, the parents also needed to problematise the nursing framework in order to identify the parameters of its relevance to their daily context and to identify any tacit or inherent oppressive assumptions within the framework or external to the framework which impacted on their lives and their capacity to either optimally care for their child or to have the emotional and physical availability to apply and utilise the information they had accessed. The combination of the inductive analysis and the application of critical theory within the supportive group atmosphere appeared to support parents to engage in this.

Working with Contradictions

The thesis has helped me to recognise not only the importance, but also the tensions of engaging in emancipatory nursing research (Henderson 1995) when working with parents, who are also clients. It illustrated how critical theory provides one way of negotiating some of the tensions. Although critical thought has evolved and undergone considerable changes and interpretations, as discussed earlier in chapter four, the thesis has illustrated that Marx still has relevance not only to critical social

research (Harvey 1999) but also on explaining everyday practice in CAMH. Marx identified that the social order caused social illusions that function to maintain oppression (Crotty 1998). In this thesis, I have recognised that the positivist paradigm underpinning the dominant ideology of CAMH can create a number of illusions, which were described in the previous chapter. For instance, that the CAMH evidence base is factual rather than a social construction and that one of these facts is that parents are to blame for the challenging behaviours exhibited by their children. Such an illusion can beget further illusions as illustrated in the findings from the thesis e.g. if parents are to blame, then society does not need to take accountability for children with challenging behaviours or to acknowledge that challenging behaviours increase with socio-economic difficulties because challenging behaviours arise solely from the inadequacy of parents.

However, the thesis has acknowledged the philosophy put forward by Foucault (1982) that oppression that can arise from the power of knowledge as well as the material means of production, discussed by Marx. Thus, there are also illusions related to the construction of knowledge as well as those arising from a socio-economic source. One such illusion is that behavioural norms are functions of universal child developmental stages rather than constructions of dominant groups in society, which can lead to an oppressive assumption that all children are equally capable of conforming to these universal norms. This leads to another example of individual blame in which the children who fail to conform to norms are labelled as either mad or bad individuals.

The thesis has also identified the oppression arising from gender and paternalism as discussed by, for example Swigart 1991 and Ruddick 1989 and 1994 and the theories and experiences of mother blame (Caplan 1998)

The thesis does not intend to add to the already large body of feminist literature related to these different forms of oppression, but rather to identify the practice implications of failing to acknowledge these, when practicing or researching a complex area such as CAMH. As discussed in chapter two, the key messages from the current body of CAMH research are that in a context of high needs and finite resources, there is a need to develop interventions, which have effectiveness in the actual practice situations as opposed to efficacy in control trials (Hoagwood et al 2001; Henggeler et al 1995) and that these interventions must be acceptable and accessible to clients to prevent drop out from expensive resources (Cunningham et al 1995). The findings from the thesis identify why interventions, which are medically and individually focused and derived from trials can produce problems of low uptake and ineffectiveness in different social contexts, because they are not developed in partnership with parents.

The thesis has thus illustrated to me the critical practice and practice research importance of applying the development of western critical theory to practice. Critical theorists such as those of the Frankfurt school, provide an alternative to the prevailing positivist paradigm as well as a forum for the discussion of Marxist ideas (Crotty 1998). Habermas (1984) for instance, called for a critique of the coercive nature of society and described emancipation as a process achieved through mutual understanding, critical understanding and communicative competence. The importance to nursing of the work of Habermas (1984) is that he proposes that

research with a critical focus is needed to expose concealed domination and oppression. Such research would uncover and analyse hidden power structures and be committed to liberating change (Falk-Rafael 2005). Through the thesis, I have developed an insight into the potentially oppressive nature of CAMH and the potentially oppressive nature of psychology and psychiatry. However, I have also become aware of the potential oppression in CAMH nursing itself. The parents critique of the nursing framework and propositions derived from the previous study illustrated that that nursing research, upon which this thesis builds, had failed to take into account the importance of an individual's social context and the many psychosocial factors, which can act as intervening variables in transferring knowledge from the therapeutic milieu of a residential CAMH setting to the community. Failing to engage in critical caring (Falk-Rafael (2005) in which knowledge is derived from an individual, social and emancipatory/critical caring perspective can result in nurses uncritically supporting the status quo in the delivery of CAMH services.

Lessons Learnt from this Research

Although considerable work has been done in working with parents, I have become aware that developing emancipatory CAMH nursing in collaboration with clients is in its infancy. However, I have learned the increased richness and depth that can occur through working with clients as research participants. This thesis has also developed my insight into the opportunities for increasing the total system capacity by working in partnership with parents within their own context.

The application of critical theory to child and adolescent mental health has helped me to recognise the extent to which the daily tensions and oppression (both tacit and

explicit) which parents face can impact upon their health and capacity to respond to their children by limiting their sense of control and constraining their potential to be advocates for their children. I feel I would not have achieved this level of insight unless I had engaged in this research, which has enabled me to integrate the delivery of a service as a practitioner, whilst simultaneously engaging in research in partnership with clients.

However, I have also learned the benefit of research and knowledge derived from an emperico-analytical approach as a tool to systematically interrogate and make sense of practice situations. Supporting parents to access and critique this empirical literature has helped parents to access and critique the dominant language and ideology which govern CAMH practice, which they can use as currency to negotiate ways of meeting their needs and to develop a sense of control in their lives. This is a particularly important finding as the parents in this study were from socio-economically deprived backgrounds that may not have been expected to access and apply nursing knowledge derived from experiential and published literature had they not taken part in this research.

However, there are also constraints as a nurse in applying critical theory with clients such as the parents in this thesis. These can be analysed by referring again to the processes of critical theory in nursing described by Fontana (2004) and discussed in chapter four.

Fontana (2004) identified the first process of the application of critical theory to nursing as “critique” in which participants need to be able to critique, oppose and

change oppression. As can be seen from the findings, the parents were able to critique and oppose some of the oppression they experienced e.g. they recognised that schools were potentially oppressive by responding to children within a narrow set of behavioural norms and as a result of this, the parents were able to go into school and challenge this. However, the research could not change the societal power structure. Parents were not able to oppose and change the power inequities embedded in the system, which determined resources e.g. they could not negotiate access to respite care. The limitations of the approach must, therefore, be acknowledged and nurses need to take on board how to develop strategies to support parents to change oppression at a wider and societal level and as nursing professionals to develop emancipatory change strategies at a wider system and societal level.

Fontana's (2004) second process referred to 'context' in which participants should be able to contextualise the phenomenon of interest (in this case the development of knowledge and skills for children with challenging behaviours) by addressing the historical, economic and social forces working to sustain it. The parents' experiences provided a way of highlighting and critiquing these forces and identified how the professional hegemony of legitimated CAMH knowledge could be oppressive and potentially perpetuated by the simultaneous idealisation and devaluation of carers. However, engaging with parents, such as in this thesis, cannot address the wider ideology, which underpins the current societal context unless practice findings, such as those arising in this thesis, are disseminated and published in ways, which confront the dominant research and policy establishment and are given equal weight to the more positivist research evidence which currently dominates CAMH practice. Further

research is required to explore how/if the findings from this thesis and the emerging action plan can impact at a wider level.

The third process according to Fontana (2004) is political and it is perhaps in this area that critical social theory holds the greatest constraints for working with parents.

Fontana (2004, p.94) proposes that:

'Nurses conducting critical studies must understand that it is not possible to critique power and domination and remain neutral. They should use the enquiry to help participants understand and change their oppressive situations by understanding the political forces which shape them. To conduct a critical study in nursing there must be an awareness of the political nature of healthcare and nursing and researchers should make their agenda known'.

It was my aim as a nurse researcher to improve practice and the capacity to respond to children with behavioural problems. The parents' experiences helped to critique and develop the nursing knowledge. The parents initially did not have any political aims, although they did develop a group consciousness in which they felt strongly that their child had an equal right to have their needs met as mainstream children. However, there is an ethical debate related to politicising parents and raising their insights if it is not possible to achieve practice change. Nurses must therefore be explicit with parents about what can be achieved and must learn innovative ways of disseminating research findings within a political arena. On reflection, the decision to use group facilitators, who were stable professional members of the parents' community (including health visitor, school nurse and manager of the family centre) to co-work with the nurse

practitioner, was an essential strategy to ensure that the parents had the opportunity to receive continuity of support following their participation in the research. However, the large drop out of parents from those initially invited indicates that vulnerable parents need additional supports to engage in this type of research.

The fourth process is emancipation, which is defined as 'a state of being in which people come to know who they are and have the collective power to determine the direction of their existence (Cockburn and Trentham 2002:p23). Fontana (2004) and Freire (1993 and 1998) propose that this is achieved through consciousness raising. The parents in this thesis illustrated that they could take control in certain instances through developing an increased awareness. However, in this thesis they identified that they needed the support of the group milieu to achieve this and even so were still constrained by the service and political structures, which they did not have the power or authority to influence on their own. Access to parenting groups is unevenly distributed (Pugh and Smith 1996) and usually takes the form of training rather than consciousness raising. The findings from this thesis indicate that knowledge, skills and consciousness raising in the form of challenging the dominant constitutive meaning associated with interpretations of challenging behaviour, are facilitated by parents being part of groups. However, parenting groups require funding and support to be mainstreamed in local communities. The large drop out from the 75 parents invited to participate and the 25 who actually participated also indicates that groups may not be acceptable to all parents. The need for a flexible range of ways to work with parents was highlighted in the Ghates and Hazel (2004) study, when some parents identified that they would prefer information or one to one work. Thus a range of ways to raise consciousness are required. The practice framework (appendix 2)

which comprises the action plan from this research could be used in both group and individual settings. However, further research is required to explore how useful it is as a tool to raise consciousness.

A fifth process defined by Fontana (2004) was achieving a democratic structure. It has already been discussed that nurses act not only as researchers when working with clients, but also as agents of the state in e.g. child protection/disseminating public health policy. The thesis has thus identified the need for nurses to increase their own awareness through opening up their practice to the critique of clients and thus transparently acknowledge the tensions of achieving a democratic partnership with parents, when simultaneously delivering a service. However, further research and development is required to explore whether the strategies used in this thesis to respond to this tension can be useful in other settings and contexts.

The sixth process identified by Fontana is the dialectic analysis in which the tensions and contradictions in society are acknowledged. A range of contradictors were identified in this thesis:

- i) As a nurse, I could provide or refer parents to expensive therapeutic interventions, but found it difficult to access relatively small sums of money to provide respite and access to leisure facilities or other services, which are relatively cheap and have a good underpinning evidence base.
- ii) Increasing the awareness of parents to their difficult and oppressive conditions, could potentially reduce their resilience to cope.

Without critiquing their practice and articulating the contradictions, nurses could themselves militate against emancipatory practice by upholding the status quo.

The last process according to Fontana (2004) is reflexivity, which involves exploring what services could look like instead of what is currently provided. The parents in this thesis illustrated that they could intuitively provide suggestions, which were supported by the evidence base, on how to improve the service (such as access to respite care and leisure facilities) but also illustrated that access to these services was not available locally. This indicates the potential resistance of services to change and the accountability of nurse practitioners and researchers to find innovative ways of disseminating the existing evidence base in its entirety and incorporating this evidence base with research findings such as those reported in this thesis.

This research has for me provoked a dialogue between practice problems, scientific research, professional nursing research and research and client experiences and experiential knowledge and emancipatory knowledge. In doing so, the thesis has raised many complex questions, which it does not claim to solve, but has produced one way of engaging with these complex debates, in order to promote emancipatory practice change. As discussed by Byrne (1998) in chapter eight, the thesis has required a dismantling of the professional boundaries by contrasting the world of the nurses with that of the individuals (parents) with whom they are attempting to develop a practice and research partnership. The research with the nurses, upon which this thesis builds, represents the relatively well ordered predictable context of practice, where nurses work as professionals. This thesis involves research with parents, living in socio-economic and psychosocially challenged circumstances, whose lives are

characterised by stigma and struggle and who can thus be seen to be at the other end of the caring spectrum to the nurses, who by contrast were relatively well supported and ascribed a position of respect. Furthermore, parents are operating within a context which is marked by its unpredictability and uncertainty. Developing an insight into the contrast between these worlds has forced me as a professional to experience, understand and appreciate the parameters of dissemination of professional knowledge and research that can arise from the differing social context and experiences of parents of children with challenging behaviours.

Reflections on my Practice

As participative researchers, the parents have helped me to critique my previous practice and my espoused theory that as a practitioner/researcher I work in collaboration with parents and have highlighted that my former theory-in-use has often been oppressive in a range of ways:

- (1) Prior to this research I did not prioritise strategies for transferring legitimated knowledge to parents/clients in ways, which could enable parents to apply them to their context. The parents' experiences enabled me to articulate my previously tacit assumption that parents were only interested in the acquisition of experiential knowledge that was specific to their child and would either not be interested in knowledge derived from published literature or that they would not be able to utilise it as professionals can. The thesis has refuted both of these assumptions.
- (2) Although I assumed that I was a critical and reflective practitioner prior to the research, the critique arising from the parents and their experiences helped me to realise that I rarely acknowledged or questioned the hidden oppression and

tacitly oppressive assumptions underpinning my CAMH practice e.g. although I recognised that care was idealised and simultaneously devalued, I had not appreciated the way this worked to silence the voice of disadvantaged parents. Neither had I fully appreciated the extent to which parental blaming is at the heart of many CAMH explanations of challenging behaviour.

- (3) Although as a researcher, I acknowledged the theoretical and well documented tensions between developing practice research that was applicable to individualised care and developing generalisable knowledge and between the certainty of Randomised Controlled Trial's and the unpredictability of practice, my work had been involved in developing nursing practice knowledge with fellow nurses, as has the majority of nursing research as previously discussed in chapter three. The thesis has develop my insight into how this approach can unwittingly privilege nurses with the expertise on care and create a nursing hegemony in which nurses appropriate the knowledge of caring practices. Opening up the nursing practice knowledge, from my previous research to the critique and interrogation brought about by exploring parents actual experiences enabled parents to have a voice rather than be represented through the hegemony of nursing or professional practice and in doing so enabled practice knowledge to develop and the potential for practice change to emerge.
- (4) As a practitioner researcher prior to this thesis, I had not engaged in the theoretical debates, which are essential to understanding how to undertake research with clients in order to develop practice knowledge and capacity, nor had I developed the practice skills to facilitate and catalyse emancipatory research in CAMH.

Engaging in participant research with parents, using a range of approaches thus enabled me as a nurse to acknowledge the many ambiguities, paradoxes and uncertainties which arise, when engaged in research to develop practice and practice knowledge in a practice context. These include: engaging in research whilst also offering a service e.g. attempting to work in a collaborative way with parents in a context where the nurses legitimated qualification can provide a major potential for power inequalities; attempting to support an individual approach to care whilst also developing patterns of understanding that can be useful to other practitioners or parents in similar situations; fulfilling the role of an agent of the state in upholding child protection and optimising scarce resources whilst also engaging in emancipatory practice research to develop the capacity and potential of parents to meet their needs and those of their children with challenging behaviours and optimising strengths at an individual, family and community level.

A dialectic way forward requires nurses to acknowledge these tensions and to locate practice research and development within an iterative context in which knowledge is not seen as definitive, but generative. By doing this, the identification of literature which is found to be helpful in the everyday context and the experiential knowledge/themes which are generated can be incorporated into a tentative practice framework which can be dynamically refined through an iterative comparison to and exploration of everyday practice.

The thesis has also illustrated to me, however, the potential value of technical knowledge for practice that can be achieved by using it as a tool to interrogate

practice rather than a generalisable truth and thus emphasised the importance of iteratively developing a cumulative knowledge base in order to engage in the complexity of practice. This was particularly illustrated through the use of literature on 'on risk and resilience', which helped me as a nurse practitioner to use knowledge derived from logistic regression studies on risk and resilience, as a way of developing a joint understanding with the parents about their individual profile of strengths and needs and thus to highlight the range of strengths and the resilience of the parents rather than just their deficits. All of the parents across the cohorts found that access to risk and resilience research was helpful.

The terms strengths and needs as opposed to risk and protective factors were considered to be more user friendly. Parents particularly found that developing the group consciousness gave them the confidence to acknowledge their strengths and to own their individual needs. Parents can thus be collaborators in identifying their strengths and needs. They also helped to add to the body of literature on risk and resilience by identifying other needs/risks not identified in the literature e.g. at a family level, the increased risk and stress of neighbourhood harassment and at a child level, the increased risk associated with their difficulties with their concept of time. The parents also helped to identify how the application of risk and resilience literature can develop emancipatory knowledge by supporting practitioners to provide the parents with alternative ways of viewing their situation and their responses to it. Further emancipatory knowledge developed in terms of how to help the parents to critique and question the status quo, how the status quo was maintaining their risk and resilience profile and then how to change it. All of these types of knowledge have

been incorporated into the revised Practice Framework (see Appendix Two) i.e. the integrated set of knowledge emerging from this thesis has been operationalised.

The findings from this thesis thus pose a challenge to nurses and indeed other professionals to see if they can change their understanding from seeing children and families as systems with deficits to systems with strengths that can be mobilised towards self reliance and health.

The juxtaposition of engaging in nursing research and nursing practice with parents has forced me to explore how to develop a cumulative body of CAMH nursing knowledge in a pragmatic, relevant and emancipatory way. Working with parents as opposed to fellow nurses has facilitated a rich critique of nursing practice, because the parents have both forced a critique of the nursing framework and also a debate on nursing itself. Nursing research differs from empirical research, according to Rolfe (1998a) because nursing practice research focuses on the development of knowledge about individuals rather than developing generalisable themes. However, the thesis has forced me to acknowledge the tensions within nursing, which requires nurses to treat patients/clients as individuals, whilst recognising that individuals are also a function of their extant systems and at a wider level the need for nurses to increase capacity in times of high need and finite resources.

As a senior practitioner, I participated in the Health Advisory Service Review of CAMH services (Health Advisory Service 1995). The National Service Framework for Children standard 9: The Mental Health of Children, Adolescents and families (DoH and DfES 2004) appears to regurgitate the principles of the Health Advisory

Service (1995) review. Epidemiological studies have shown the same or increasing prevalence of CAMH problems identified in Rutter's Isle of Wight study carried out in the 1960's (Rutter 1989) to the major national study of Meltzer in 2000 which are comparable with the international studies of Offord et al (1991). The thesis has made me reflect as a senior practitioner and researcher, engaged in strategic planning whether the apparent lack of progress in CAMH despite the proliferation of policy and ideology from the Department of Health (2004), Mental Health Foundation (1999 and 2001) and Health Advisory Service (1995) is due not only to the weakness in the relation of efficacy of research to everyday practice (Hoagwood et al 2001), but also because there has been a failure to confront the multiple and complex issues which are involved in developing practice, developing capacity and working in partnership with clients.

Since starting this thesis, there has been a growing recognition of the importance of incorporating the user perspectives to inform practice and policy development (Department of Health 2000, 2004, Doh and DfES 2005). One aspect of user involvement is to engage in consultation with them (Department of Health 1999, 2000). However, this does not involve the users as creators of services. This thesis provides an alternative way of incorporating the user perspective into service use and to inform service and practice development. In doing so, it has identified the sophisticated debates that are necessary to engage users in research, particularly whilst engaging in research whilst also offering them a service. Although the importance of the user perspective is extolled in all government policies regarding mental health (Department of Health and DfES 2004, DoH 2000, DoH 2004) acknowledgement of and critical analysis of these debates are conspicuously absent.

As a nurse practitioner with an aim of developing emancipatory research, I must also acknowledge that of the 75 parents, who initially agreed to participate in the research, only 25 subsequently attended 75% of the sessions and were able to contribute to an action learning cycle, which formed the basis of the data analysis. Although 45 parents attended the first session of each cohort across the eight cohorts, 20 of these did not attend subsequent sessions. The 20 parents across the 8 cohorts, who subsequently dropped out did not seem able to participate in the first session of each cohort. In an ideal study, these parents would then have been followed up to discover why they dropped out, but time limitation meant it was not possible to do this. The limitations of the thesis in accessing parents, who felt able to participate in emancipatory research, must therefore be acknowledged. However, as discussed in the literature chapter, the drop out rate was consistent with other research on parenting groups (Cunningham et al 1995; Smith and Pugh 1996). It could therefore be argued that an advantage of the thesis was that it was possible to collaborate in a research project with a very vulnerable population of 25 parents, who traditionally do not access or maintain attendance at parenting groups (Puckering 1996; Whaler and Hammond 1990), let alone engage in participative research. Furthermore, the research indicates that the participation of these 25 vulnerable parents not only increased their own capacity to respond to their children with challenging behaviour problems, but increased the systemic capacity by increasing the insight of professionals into the parents' lived experiences and also potentially providing a way forward for policy makers, who search for both cost effective as well as therapeutic strategies, through theorising the findings from the parents. This led to a theory that service led strategies can actually reduce capacity, whilst responding to families

expressed psychosocial needs can increase the total system capacity to respond to children with disruptive behaviour problems and challenging behaviours. Although it is likely that the 25 parents actively participating parents represented the most resilient of the 75 parents invited to participate, their participation in emancipatory practitioner research has formed a platform upon which to build further research and provided valuable practitioner knowledge on how to engage vulnerable parents and to maintain their participation in an emancipatory practitioner research study. Further research is required to continue to explore how to increase the engagement and maintenance of the most vulnerable group of parents in parenting groups and emancipatory research in order for them to become creators and not just users of services. One way to make them more accessible is to provide transport, but this would require the investment of money and therefore a case would need to be made to service planners and research and development strategists.

Another way to promote acceptability maybe to decrease the stigma associated with attending a targeted group for parents of children with behavioural problems. This can be done by situating the groups in community centres, which are not health linked i.e. have a universal purpose (Cunningham et al 1995). It can also be achieved by developing groups of both universal participants (i.e. recruited from the general population) and targeted (i.e. meet criteria of having a child with behaviour problems). More work will also be required in the future to explore the gender issues, e.g. no fathers attended the groups or participated in the research.

More work also is required in future research to do participative research with fathers to explore their contribution to care and with children and to explore their experiences of care. One of the potential ways forward is to articulate the sophisticated knowledge and skills base underpinning care. It is essential, however, to discover the best way to disseminate these to policy makers and service planners and to explore how other carers of children with behaviour problems such as teachers and play workers feel that they can be best supported to deliver care. This chapter has reflected on how the practice framework can be used to empower parents and deal with this. However, it has also reflected on the ethical issues, for example, there was also an ethical imperative to ensure that the parents in each cohort continued to have support to cope with what may be difficult feelings related to how oppressed they and their children may be.

In conclusion, the value of this thesis lies its “catalytic validity” (Reed and Biott 1995, p. 191) to be a platform that can generate further research and to be a lever to develop a cumulative body of practice knowledge, to inform non oppressive practice and practice-research development in the future, with parents and their children, who have challenging behaviours and how to develop capacity to respond to CAMH issues by engaging in emancipatory research within a critical caring approach. The thesis demonstrates that engaging in research with clients whilst also engaged in practice is a complex and problematic process, which requires an innovative combination of methods. The thesis does not aim to provide the ultimate solution, but proposes that practitioner research carried out in participation with clients can integrate research from both the medical and social model and critical caring model within the practice context and thereby develop a cumulative body of emancipatory practice knowledge,

which acknowledges and addresses the complexity, uncertainty and unpredictability of clients 24 hour experiences. This can maximise the total set of resources available to both support families and also optimise the capacity of professionals and service providers to develop insightful and non-oppressive solutions to CAMH problems.

The emerging field of realist synthesis (Pawson et al 2004) recognises the theoretical complexity of practice and service delivery and the need to integrate evidence from a diverse range of research, sources and research methods. This thesis represents one way to pragmatically operationalise realistic synthesis in practice and the future development of realist synthesis may be of relevance to further studies of this kind.

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Appendix 1

Practice Framework for Development of Self Control: developed from Nursing Project (Croom 1996; Croom et al 1999)

Potential Observable themes/Criteria for diagnosing level/stage of control developed
as derived from concept analysis attributes and practice interviews/questionnaires

Name of Child: Age of child:

Date: Relationship of reporter to child:

Attachment/relationships

Observable Criteria:

		<u>Usually</u>	<u>Sometimes</u>	<u>Rarely</u>	<u>Not observed</u>
1.	Can the child respond selectively to a significant person whom they have identified?				
	Does the child seek out the company of the significant person?				
	Does the child turn to them for comfort if they are distressed?				
	Does the child respond to advice/support given by significant carer?				
2.	Does the child seem to be "in tune" with the significant person?				
	Can significant person predict Child's behaviour? When child is stressed? the kind of support child needs?				
	Does child seem to be able to interpret cues of significant person e.g. when he/she is joking, happy, serious upset				
	Can child begin to predict responses of significant person e.g. if I draw picture they will be pleased, if I make a mess they will be unhappy, if I ask them to play with me they will probably say yes etc.				

Photo
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3.	Peer relationships	<u>usually positive</u>	<u>Sometimes positive</u>	<u>tries but is unsuccessful</u>	<u>aggressive /negative</u>	<u>doesn't try</u>
	What kind of relationship does child form with peers?					
	Can child approach peers in a positive way?					
	Can child engage in positive activities with peers?					
	Can child understand peers' point of view e.g. in argument/negotiation?					

4.		<u>usually</u>	<u>Sometimes</u>	<u>rarely</u>	<u>not at all</u>
	Is child predictable in peers company?				
	Is child supportive of peers e.g. when peer is upset/frustrated?				
	Is child popular among peers?				

Pause/Break

(please circle)

When under stress/wound up: Can child accept diversion/support?	usually	sometimes	rarely	not at all	
Can you get child to stop and think before acting?	usually	sometimes	rarely	not at all	
How often does child need to be supported/diverted in course of day?	0 - 1	1 - 3	3 - 5	5 - 10	more than 10
Is this more than you would expect for child's age?	Significantly more	a bit more		about right for age	
What kind of diversion helps e.g. being there, giving space, physical comfort?					
Can child stop and think before acting when under stress/wound up	usually	sometimes	rarely	always act on impulse	
How long can child deal with a frustration/stressor before reacting	less than 20 seconds	less than minute	up to 2 minutes	more than 5 minutes	

Ability to perceive social reality/process information effectively:

	<u>usually</u>	Sometimes	<u>rarely</u>	<u>never</u>
Can you get child to stop and think before acting?				
Do they feel a situation where child has acted inappropriately/aggressively is always "somebody else's fault?"				
Can the child explain what the problem appears to have been?				
Does child seem to understand a limit which has been set?				
If a child loses control, can they generate solutions to how similar situations may be resolved in future?				
Can they generate solutions with adult help?				
Have they been able to carry out solutions generated?				
Does child seem to be able to learn from their experiences				

Able to interpret/understand social context and produce developmentally appropriate responses

	<u>appropriate to age</u>	<u>somewhat immature for age</u>	<u>very immature for age</u>
Level of social skills			
Understanding of social rules and limits			
Ability to abide by social rules and limits			
Ability to take another's point of view			
Ability to respond to another person's distress/anxiety/Discomfort			

Sense of mastery:

	<u>usually</u>	<u>sometimes</u>	<u>rarely</u>
Can child control impulses in a particular setting? (please specify)			
Can child control impulses in a number of settings? (please specify)			
Can they regulate their feelings across a range of settings?			
	<u>socially</u>	<u>emotionally</u>	<u>physically</u>
Do they seem to be functioning at a developmentally appropriate level?			
Is the support you provide appropriate to that child/young person's age?			
Is the level of social/physical emotional support you give to child appropriate to age/development?			

Physiological predictors:

(Please circle)

Level of arousal:	<u>usually</u>	<u>sometimes</u>	<u>rarely</u>	<u>never</u>
Physical agitation - does child display physical agitation when frustrated?				
Does child display psychomotor signs e.g. red face, white face, hand tremor, shaking, reported feelings of being dizzy, heart thumping etc. - list	Please specify observations:			

Experiential predictors:

Observed events/behaviours which have been noted to trigger a child to use self control e.g. being confronted, being called names, being upset/disappointed with external event e.g. no phone call, upset at own performance e.g. loss of game, cakes not turning out as they wanted, feeling rejected etc. - list	
--	--

Other - please specify				
Is it difficult to determine triggers which lead to a child losing control?	most of the time	sometimes	occasionally	rarely

Motivation to develop strategies which can help develop self control and act in socially appropriate manner:

Does child appear to try to maintain self control:	<u>most often</u>	<u>sometimes</u>	<u>occasionally</u>	<u>rarely</u>
(a) to please significant person				
(b) to establish sense of autonomy/competence				
(c) to avoid negative consequence				

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Appendix 2

Practice Framework for Working jointly with Parents and Young People to identify Child and Adolescent Mental Health (CAMH) Issues and how to reduce the likelihood of CAMH problems and to build on the strengths of the young person, family and the community they live in.

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Information for parents: Background and aims of the Practice Framework

1. INTRODUCTION

1.1 Background

As professionals, we realise we do not have all the answers. We need to learn more about the best ways of supporting children with challenging behaviours to achieve their developmental potential throughout the whole 24 hour day. We also need to know more about supporting parents to do this. By working together on this framework, we hope to learn more about your situation, to share information with you and also to learn from you.

1.2 Continuing Research: Your Participation

This framework has developed through joint research with parents. It aims to help you and your family be listened to and heard. Parents in the research taught us a number of things. It would be helpful to find out how many of these would also apply to you.

- 1.2.1 How physically and emotionally exhausting it is to cope with a child who has challenging behaviours. This is made even worse when there are other stresses such as money worries, housing concerns or family difficulties.
- 1.2.2 How isolated parents can feel because they feel they are the only ones coping with children with challenging behaviours.
- 1.2.3 How parents can be made to feel guilty and inadequate even when they are doing their best under difficult conditions.
- 1.2.4 Parents feel that they would like more support to have some short breaks themselves so that they can "recharge" and to help their child get into recreational activities, which can cope with children with challenging behaviours.
- 1.2.5 Parents do not receive all the information from professionals, which they feel would be helpful in managing their child.
- 1.2.6 How information, which could help people develop more understanding attitudes to children with challenging behaviour is not widely shared or available. This lack of understanding of a child's needs can lead to the family

experiencing tensions with schools, neighbours and for their children with joining in recreational activities.

- 1.2.7 How useful information and support from other parents who have children with challenging behaviours can be
- 1.2.8 How parents want to have their strengths and expertise acknowledged, but do not wish to have their needs dismissed or minimised.
- 1.2.9 That professionals need to do a lot more work with parents to develop a shared understanding of the best ways to manage children with challenging behaviours over a 24 hour period. That is why we wish to continue to learn, and one way of doing this is by working through this framework.
- 1.2.10 That we do not currently have enough resources to meet the needs of children with challenging behaviours. We can work together to make best use of the resources which the families and children have themselves, and the resources in the community and to identify the kinds of changes in services, which parents identify would be helpful to them and their children

1.3 Is there anything you would add to this?

1.4 Sharing Information

We would like to share with you some of the information, which parents in the research found to be helpful to them such as some of the published literature on:

- 1.4.1 Understanding how some children are genuinely easier for some parents to develop a rewarding relationship with than others.
- 1.4.2 Understanding why some children are more predictable and easier to manage than others
- 1.4.3. Understanding how some children are more impulsive than others.
- 1.4.4 Understand how some children can find it more difficult to take information on board than other children.
- 1.4.5 How as parents, we do experience negative feelings about our children but how we may use these feelings in ways which can help us to continue to care for our children.

We will share information with you on some strategies which parents in the research found were effective for dealing with children who have challenging behaviours. We will also share what is available in the community. We hope this will help you make an informed choice about how you feel you can best use the research evidence and your family resources as well as have a say in how you would like to access services which currently exist.

1.5 Summary of Aims of Practice Framework

In summary, the aims of working together on the framework are to:

- 1.5.1 Recognise your strengths and learn from your expertise as parents in understanding and managing your child
- 1.5.2 Acknowledge the stresses you are experiencing in your family life, which make management of your child more difficult
- 1.5.3 To give you the opportunity to have information shared with you, which may help you in understanding and managing your child's needs
- 1.5.4 To support you to identify your priorities and choice of how best to cope with the needs of your child and family's needs and to build on your family's and child's strengths by helping you access the best services available
- 1.5.5 To feed back any gaps you feel that there are in the services to organisers of services

Section 2: Introduction

WORKING WITH PARENTS TO IDENTIFY THEIR STRENGTHS AND THEIR NEEDS

Information to be shared with parents: *parents can read this themselves or have the opportunity for professionals to talk it through with them*

Much has been written on research on the strengths which can help us to cope and feel good about ourselves and needs which can prevent us from doing this.

Research has helped us to understand how it is possible to identify these at an individual level (e.g. having a friendly approach tends to make others like us and so help us to feel good about ourselves), at a family level (e.g. when parents are not overloaded with stress or money or housing worries, they are better able to support each others and their children) and at a community level (e.g. we tend to cope better when we have access to good facilities such as good transport, friendly neighbours and good family centres).

Every individual and family has a unique profile of needs and strengths. Parents in the research found that knowing more about these factors was helpful in planning how they wished to tackle particular issues and also to identify who was best to help them. We would like to explore these with you now to see if you find them helpful.

2.1 IDENTIFYING STRENGTHS AND NEEDS FOR CHILD:

2.1.1 SELF CONTROL INFORMATION PROCESSING AND PROBLEM SOLVING.

Information to be discussed with parent –

Being able to develop a sense of control is important in helping children to develop their self esteem, to fit in with different situations and to develop a sense of masking over their lives. For a range of reasons, some children find it difficult to develop or maintain self control. This can make them seem unpredictable and explosive and can interfere with their every day lives and their ability to meet their social, emotional and developmental goals. There can be a number of reasons for this. Some children have difficulties dealing with taking on board information, recalling it and organising it. This is particularly difficult when they are anxious, angry or frustrated. They may have difficulties in being able to recognise their feelings and those of others (and this makes social communication difficult), or may have difficulties in being able to stop and think or work out what is going on and how to plan what to do when they are aroused or distressed or excited or anxious.

The person you are working on this framework with will discuss the following with you. For each question, can you think what you have done to help your child in these areas.

2.1.1.1	Does your child appear to be able to cope with everyday frustrations? 1 usually 2 3 4 5 has significant difficulties What helps your child achieve this?
2.1.1.2	Does your child have difficulties with impulsivity? 1 usually 2 3 4 5 has significant difficulties What helps/hinder your child?
2.1.1.3	Does your child ever unpredictably lose control or “explode” in way which is dangerous or inappropriate and is causing difficulties at home/school/play? 1 2 3 4 5 Home: usually sometimes has difficulties School: usually sometimes has difficulties please specify activities: What helps/hinders your child

2.1.1.11	Can your child keep to rules/limits:
	<div>1 2 3 4 5</div> <div>Home: <i>usually</i> <i>sometimes</i> <i>has difficulties</i></div> <div>School: <i>usually</i> <i>sometimes</i> <i>has difficulties</i></div>
2.1.1.12	Does your child have difficulties learning from consequences of behaviour - e.g. seems to do the same thing over and over again:
	<div>1 2 3 4 5</div> <div><i>often</i> <i>sometimes</i> <i>usually learns his/her lesson</i></div>
2.1.1.13	Can your child develop solution to situations they find difficult if adult sits and talks them over with him/her?
	<div>1 2 3 4 5</div> <div><i>usually</i> <i>sometimes</i></div>
2.1.1.14	Can your child put these solutions into action?
	<div>1 2 3 4 5</div> <div><i>usually</i> <i>sometimes</i></div>
2.1.1.15	Does your child seem to have a growing sense of self confidence at home/school?
	<div>1 2 3 4 5</div>

STRENGTHS AND NEEDS OF CHILD:

2.1.2 RELATIONSHIP SKILLS

Information to be shared with parents

Children learn many of their early skills through their caregivers. This includes their ability to develop relationships, to understand how other people are feeling, to be able to conform in order to please their care giver and their feelings of self esteem and confidence. This is a complex two way process between parents and their children. Difficulties can arise for a variety of reasons. Sometimes some children are more difficult to connect with or get in tune with than others. Some children have difficulties with developing the skills to understand how to understand and respond to others. Sometimes parents can be so stressed that this "connection" becomes difficult. This means that sometimes a child and their parent(s) may need extra support and help to achieve the kind of relationship which can develop spontaneously with another child and parent.

2.1.2.1	Does your child tend to approach adults and carers with a positive attitude <i>Usually</i> <i>sometimes</i> <i>rarely</i> <i>tends to have negative/ aggressive attitude</i>
2.1.2.2	Do adults tend to respond positively to your child?
2.1.2.3	Does your child readily seek out adult support: (i) if distressed: <i>usually</i> <i>sometimes</i> <i>finds this difficult</i> (ii) if help needed: <i>usually</i> <i>sometimes</i> <i>finds this difficult</i>
2.1.2.4	Does your child find it difficult to ask for help: Home <i>usually</i> <i>sometimes</i> <i>finds this difficult</i> School <i>usually</i> <i>sometimes</i> <i>finds this difficult</i> Other <i>usually</i> <i>sometimes</i> <i>finds this difficult</i>

2.1.2.5	<u>If appropriate:</u> Can engage in age appropriate activities without adult supervision: <i>usually sometimes difficult – easily gets distracted and into trouble</i>		
2.1.2.6	Some children can find it difficult to build on their early relationships to develop their skills and other relationships and may need extra support to transfer from one setting to another.		
	Is your child:	Nursery school	Primary school
	<ul style="list-style-type: none"> • Able to confidently separate from parents • Able to keep rules • Enjoying activities • Learning to get along/coping with peers • Making some friends • Developing good adult relationships • Achieving academic targets • Reading appropriate to age • Reluctant/makes excuses to avoid going to school 		

Strengths and needs of child (continued)

2.1.3 Leisure activities – Information to be shared with parents

Recreation and leisure activities have been found to be very effective in helping children's self esteem and development. Some children need some extra support to help them attend e.g. they may not have the confidence, the difficulties/challenges of their behaviour are difficult to meet in local leisure activities and activities can be expensive. This section helps us to develop a shared understanding of the possibilities for your child and family:

2.1.3.1	Does your child engage in any activities/hobbies outside of school hours?
2.1.3.2	What activities would you/your child like to take part in?
2.1.3.3	What could help you and your child to achieve this?

STRENGTHS AND NEEDS OF CHILD: (continued)

2.1.4 Temperament – Information to be shared with parents

We are all born with a particular temperament. This makes us naturally more likely to behave in one way rather than another e.g. some children are very relaxed, laid back and easy going and others are more likely to be extremely active with a tendency to go on and on. This makes some children naturally easier to respond to and others more challenging and stressful to manage. This is not their fault and is not the parents' fault. Both the child and parent may need support to help the child cope. . All of these children can be successful and find their own strengths if they are helped e.g. a very active child may have the energy to be a real leader in the army. Difficulties can arise if the people who look after the child for significant periods e.g. teachers, parents, grandparents find it difficult to work out how to manage and best support the child. This section will help us develop a shared understanding of your child's behavioural style and how their strengths can be built on, and their challenging behaviours managed so that they can fit into whatever setting they're in.

Is your child:

2.1.4.1	Generally in a good mood/easy to please?
2.1.4.2	Moody/tends to be difficult to please?
2.1.4.3	Finds change of routine very difficult?
2.1.4.4	Finds new activities difficult?
2.1.4.5	Finds changing from one activity to another difficult?
2.1.4.6	Distractible – flits from one situation to another?
2.1.4.7	Very active to a point, which causes problems for those around him: Home – School –
2.1.4.8	Persistent – goes on and on if he/she wants something?
2.1.4.9	Is difficult to comfort/console/calm down once he/she gets upset?

Adults who care for child find him/her:

2.1.4.10	Easy to manage
	Can manage them with extra effort
	Find child difficult to manage?
	Feel as though they're in a constant battle with child (for the above please specify context e.g. home/school/other)

2.5 Potential that child may need extra support because they may have a mental health disorder:

There are some important questions, which have been found to help identify how serious a child's problem is. We will go through these now.

2.5.1	Has there been a change in usual mood of your child:
2.5.2	<p>Has there been a change in the way your child engages with activities, the level of enjoyment they get from them</p> <p>Has there been any signs your child is not developing as well as before e.g. in their self esteem/confidence in making and playing with friends at school.</p>
2.5.3	<p>Is your child's behaviour causing problems or distress in daily life:</p> <ul style="list-style-type: none">• with peers• at school• in everyday family life• to parents/brothers/sisters
2.5.4	How long have these problems/this distress lasted?

Section 3: STRENGTHS AND NEEDS: Family

There are additional stressors, which can contribute to parental difficulties in managing a child with challenging behaviour e.g. family mental illness, problems in family of drug or alcohol misuse, problems in family with breaking the law/problems with police

There are also many strengths which help families cope despite difficulties.

It can be helpful to identify family strengths and needs and we will work together on this now:

3.1	Are you a single parent family, two parent family?
3.2	Have you or your partner been married before?
3.3	Do you find that as parent(s) you can discuss problems which arise without getting into argument with: usually sometimes often results in arguments (a) each other (b)with child/children:
3.4	Do you find that as parent(s) you can set and enforce age appropriate limits? usually inconsistently finds it difficult
3.5	Do you know where child is/what they're doing during day/evening? 1 2 3 4 5 always can't keep track of them
3.6	Do you get support from extended family? 1 2 3 4 5 very supported no support
3.7	Do you receive support from friends/neighbours? 1 2 3 4 5 very supported no support

	Yes	<i>didn't feel cared for</i>
3.16	<p>What does your family enjoy together? (please specify activity and frequency of activity)</p> <p>What factors prevent your family from engaging in these activities?</p>	
3.17	<p>What kind of activities/hobbies do parents enjoy (please specify activity and frequency of activity)</p> <p>Are there any factors which prevent family/individuals from engaging in their hobbies/spare time activities?</p>	
3.18	<p>Have there been any recent bereavements?</p> <p>Family:</p> <p>Friends:</p> <p>Pets:</p>	
3.19	<p>Have there been any recent house/neighbourhood moves?</p>	
3.20	<p>Did you, as parents, ever experience difficulties growing up?</p> <p>(a) childhood</p> <p>(b) schooling</p> <p>Any interventions which were put in place to cope with these problems</p>	

Section 4 – STRENGTHS/NEEDS – COMMUNITY

4.1	Do you live in a close, stable neighbourhood? <div style="display: flex; justify-content: space-between; padding: 0 10px;"> 1 2 3 4 5 </div> <i>close, tight knit</i> <i>lots of problems</i>
4.2	Do you have: (a) community groups/family centres? (please specify) (b) parenting groups? (please specify) (c) youth clubs? (please specify)
4.3	Do you receive social/unemployment benefits?
4.4	Are you concerned about any debts?
4.5	Do you have concerns about your housing?
4.6	Are there regional bus routes, easily accessible shops, easily accessible health services? (any other – please specify)
4.7	Have there been any major crises, events in area, e.g. major accidents, loss of main employment source?
4.8	Have you ever experienced any discrimination: social, racial, gender in your community?
4.9	Is there a problem with crime/drug misuse in neighbourhood in your community?
4.10	Do you feel your child's school has difficulties with e.g. bullying, racism, behavioural problems?
4.11	Do you feel you have a good relationship with the staff of your child's school?
4.12	Do you have a supportive GP, health visitor, school nurse or other professional?

5. JOINT PLANNING WITH PARENTS/YOUNG PEOPLE - Feedback:

- 5.1 Strengths which help you currently cope/demonstrate parental expertise
- 5.2 Needs as identified by parents and their priority
- 5.3 Needs as perceived by professional and priority
- 5.4 Joint agreement of strengths and needs
- 5.5 The person working on this framework with you will discuss a range of ways in which your needs can be understood and your strengths built on. This is intended to help you make a decision on which are most helpful, feasible and acceptable to your family in your community and social context.
- 5.6 Agreement with family of most helpful ways to reduce needs and promote strengths.
- 5.7 Discussion on need to refer to other agencies and obtaining parental permission
- 5.8 Agreed criteria upon which to base evaluation/discuss whether things are working.

Section 6: FOLLOW UP: Joint evaluation with children, young people, parents/
other agencies

Discussion about resilience

We have been working together on this to help you and your family develop your resilience i.e. so that you feel you can cope despite difficult situations.

Following our previous discussion:

What strengths do you feel you've drawn on?

What needs do you feel you've worked on?

What has helped you to achieve this? If you feel the situation is still very difficult, what has helped you to keep going?

What strengths do you feel you've worked on?

What needs do you feel you've worked on?

FURTHER PLANS: Continue current strategies/negotiate further strategies to alter
risk/resilience profile

Any referrals negotiated:

Date for next session/evaluation:

7. If current work completed:

- 7.1 Discussion on how family resilience has been promoted and family needs have been reduced so far
- 7.2 Discussion on ways of maintaining this
- 7.3 If work completed, ways of maintaining health: prediction of future "crisis" or vulnerabilities and potential action plan to respond to this.
- 7.4 What gaps do you feel there are in the provision of services for you/your child?

Signed: (as relevant e.g. child, parents, professional)

Date:

Thank you for your help in working together on this.

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Developing a concept analysis of control for use in child and adolescent mental health nursing

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Developing a concept analysis of control for use in child and adolescent mental health nursing

The need to help children and young people with significant mental health problems develop a sense of personal control in their everyday lives, in a manner which does not endanger themselves or others, was recognized by nurse practitioners working in an English regional multidisciplinary child and adolescent mental health residential unit. A concept analysis of control was undertaken and used to develop a framework for analysing control. This deductive framework was modified iteratively by nurses who developed new knowledge from a qualitative exploration of current practice and the application of the evolving framework to practice problems. The paper describes this process and highlights three main findings: (i) the evolving attributes of the concept analysis helped nurses steer a course through the complexities of practice; (ii) the research highlighted and enabled nurses to confront the paradoxical nature of control; (iii) the process enabled nurses to recognize the mutuality of feelings aroused simultaneously when both the nurse and the child are challenged to maintain personal control.

Keywords: child and adolescent mental health nursing, concept analysis, control, participative action research, nursing theory

INTRODUCTION

One hallmark of professional practice is the delineation and control of a specialist body of knowledge (McDonald 1995) usually derived from a high status source such as

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academia. Within this paradigm nursing's claim to practice holistically creates a concern as to how any one individual or profession can acquire the full spectrum of specialist knowledge assumed to be necessary to sustain this claim (Reed & Procter 1993). In common with other areas of health care, the field of child and adolescent mental health is characterized by a range of specialist knowledge bases derived from non-nursing research, for example psychiatry and psychology in mental health. At the same time the research base in nursing remains relatively underdeveloped. In advocating a holistic stance nursing confronts the problem of delineating a unique knowledge base and simultaneously negotiating the overlapping boundaries between nursing and the specialist knowledge of a myriad of other professionals.

This paper describes a study in which a concept analysis (Walker & Avant 1988) on the topic of control was undertaken using literature derived from a diverse range of specialist sources. This was combined with action research methodologies and used to analyse nursing practice and explicate nursing knowledge about personal control in a child and adolescent mental health in-patient setting. The findings illustrate how, through analysing a diverse range of specialist knowledge in the context of practice specific situations, it is possible to abstract a range of relevant specialist nursing knowledge and to communicate this knowledge to other colleagues.

DEVELOPING KNOWLEDGE FROM PRACTICE

The issue of developing professional knowledge has been greatly influenced by the work of Schön (1987) and Eraut (1994). Schön's work casts doubt on the transferability of knowledge produced in de-contextualized, controlled academic environments to the messy, 'swampy' world of practice. Schön's work drew on the professional practice of a diverse range of practitioners to illustrate the artistry involved in adapting technical knowledge to the idiosyncratic contexts encountered by practitioners. He proposed that expert practitioners were those who had developed the ability to adapt and to integrate technical and experiential knowledge at the point of implementation. Schön (1987) identified reflection as a process of knowledge attainment emerging in practice which he claims is best suited to solving complex practice-based problems. Eraut (1985, p. 131), in discussing the generation of knowledge from practice, suggests that the role of the researcher must change from that of creator and transmitter of generalisable knowledge to that of enhancing the knowledge creating capacities of individuals and professional communities'.

In deriving knowledge from practice there is always a problem of perpetuating custom and practice. Freidson (1971) has argued that the professional's world is one which is prone to be self-validating and self-confirming.

Reflection may form part of a self-validating cycle of knowledge generation (Doyal 1993). From a qualitative methodological perspective the concept of 'anthropological strangeness' (Garfinkel 1967) of non-practitioners might potentially augment the findings and analysis of the practitioner researcher by recognizing the history, values and beliefs which have perhaps become too familiar to practitioners to be explicated. Despite these problems with qualitative methodologies there is acknowledgement of the need for nurses to derive knowledge contextualized within the reality of practice, creating findings that are generative rather than generalizable for practitioners in other practice settings (Benner & Wrubel 1989, Fish & Puir 1991). However, the use of predominantly qualitative methods in nursing research has not fully addressed the question of how a cumulative knowledge base can be developed which builds systematically on existing empirical research findings.

THE STUDY

Aims

This study aimed to investigate whether concept analysis combined with qualitative methods of data collection could:

- increase practice-based knowledge used by nurses in the clinical setting;
- change the way in which nurses implemented care;
- aid communication between nurses; and
- aid communication between nurses and other members of the multidisciplinary team.

Control as an aspect of nursing practice

The topic of control was identified by nursing practitioners in the unit as causing significant distress. Concern was expressed about how nurses could help distressed young people with psychiatric/mental health problems develop a sense of *personal control* in their lives in a manner which did not endanger themselves or others. Within the literature on child and adolescent mental health the achievement of personal control has long been identified as a critical component for achieving other social and emotional developmental tasks (Erikson 1959). Both Seedhouse (1986) and Doyal & Gough (1991) have put forward philosophical definitions of health in which the effective exercise of personal autonomy is distinguished as the defining characteristic of health.

A lack of personal control was highlighted in children with conduct type disorders, who are characterized by chaotic disobedience, disruption and aggression (Wolf 1971) and who seem to lack the strategies to maintain a sense of personal control, even when doing so would

enable them to achieve their own desired goals. It was also identified as a key feature in young people with anorexia, who may avoid food out of a fear of losing personal control (Garner & Bemis 1982) and so appear to have a chronically unhealthy strategy for maintaining a sense of personal control.

Methodology

The design for the research drew on the principles of practitioner research (Reed & Procter 1995), reflecting the fact that the key researcher was herself a nursing practitioner on the unit holding a senior nursing post within the unit. From this perspective it was recognized that the main emphasis for the research was the development of nursing knowledge and not the development of knowledge about nurses. In order to integrate the research with practice the research also utilized principles of participative action research Cohen (1985).

The participating team members were the experienced nurses on the unit, who not only provided data through interviews, focus groups and critical incidents but also contributed to analysis of the data and the implementation and further investigation of the findings from the study. The participants were not therefore classified as research subjects, rather as fully contributing members of the research team which was co-ordinated by the key researcher.

Methods of data collection

Three methods of data collection were used in this study and these are described below.

Concept analysis

The concept of control reflected the features of ambiguity and lack of clarity identified as characteristic of concepts requiring further clarification (Walker & Avant 1988, Morse 1995). As one experienced nurse described:

We're always talking about whether a child has developed inner control or not, but what does that really mean...? You're trying to help them achieve a sense of control but there's nothing really written down, no guidelines which say 'If this fails, do this'. It's like a magician pulling something out of a hat and you hope you're going to achieve a happy medium which is acceptable to the child, yourself, your colleagues... the lawyers.

A concept analysis was conducted using the framework developed by Walker & Avant (1988). The concept analysis produced an initial set of attributes or characteristics associated with the concept of control identified from a broad range of literature. These attributes begin to differentiate the critical criteria by which the concept can be named and framed in the context of the 'muddy' and blurred world of practice.

Interviews

Semi-structured open-ended interviews are used frequently in qualitative methodology to elicit perceptions, meanings and interpretations given by participants to the subject under study. As Silverman (1985) points out, the strength of interviews resides in providing insights into interpretations of behaviour, but on their own interviews give no information on the accuracy of the accounts of behaviour described in the interview and this must be acknowledged when working with interview data.

Critical incident technique

Critical incident technique involves the collection of contextualized stories, incidents or vignettes from respondents that are used to analyse a selected aspect of nursing practice. They can further be used to explore and evaluate previously held conceptual frameworks through the process of critical reflection (Smith & Russell 1993).

Sample population

In undertaking this project the complex philosophical and ethical issues surrounding the concept of control were recognized and a decision was taken to start the research with individual interviews with senior nurses in a regional multidisciplinary child and adolescent mental health residential unit in the north-east of England. This was considered to be important in order to facilitate an in-depth exploration of an ethically difficult concept in a confidential setting. Later, focus groups were used to access group norms and to explore the meaningfulness and relevance of the evolving concept analysis of control to the everyday care of a wider range of nurses in the unit.

Stages of data collection

The data in the study reported here were gathered in a series of stages.

Stage one: concept analysis

The concept of control was analysed following the principles described by Walker & Avant (1988).

Stage two: critical incidents and interviews

Critical incidents were derived from in-depth, semi-structured interviews conducted with three senior nurses of 'G' grade and above with a minimum of 5 years experience in child and adolescent mental health.

Stage three: introduction of the concept analysis to the qualitative research process

Focus groups involving the entire nursing staff (21 staff from 'A' grade to 'G' grade) were conducted. Members voluntarily completed written critical incident forms which were then discussed. This was followed by an

exploration of the perceived relevance (or lack of it) to practice, of the currently modified concept analysis.

Stage four: application of the concept analysis to current clinical situations

Further focus groups were held including three 'G' grades, three 'E' grades and an experienced nursery nurse. Here participants reflected on their care of children currently in the unit. The care was discussed in the context of the evolving concept analysis, and the strengths and limitations of the concept analysis in making sense of the meaning underlying the practice cases were explored.

All interviews and focus groups were recorded with the permission of the participants and transcribed verbatim. Copies of the transcripts were distributed to participants for validity checks and to delete any data considered unsuitable by the nurse for inclusion in the research.

Data analysis

In undertaking the initial work on concept analysis Wilson (1963) proposed that the concept can be modified according to new practice experiences and new scientific knowledge. A dynamic tension (known in this paper as the iterative process) is created by constantly comparing what is known empirically and theoretically (i.e. from the initial literature-based concept analysis) with what is known from experience by the practising nurses. New knowledge is generated through this comparison which can be refined further and 'tested' for its relevance by applying it to new practice situations.

Following the individual interviews (stage two) the evolving concept attributes were further refined and tested out in focus groups with experienced nurses, to identify whether it facilitated improvements in the nurse's understanding of this aspect of practice. Each iterative cycle adds further knowledge and clarification to the knowledge

and clarification derived in the last cycle. A failure to further refine the concept analysis would indicate that, within the resources and abilities brought to the iterative process by the participating team members, the process of concept analysis was exhausted. However, further development could be achieved if the findings were applied to a different situation or used by a different group of nurses. In this way, it is suggested, the iterative process described here has the potential to develop a cumulative but grounded knowledge base in nursing.

FINDINGS

Stage one

A feature which distinguishes concept analysis from a traditional literature review is that all possible uses of the concept are explored during the literature phase of the concept analysis. In the case of control this led to an exploration of psychopathological literature, engineering and cybernetics literature, and literature on social information processing. The derivation of generic attributes is considered to be a key feature of concept analysis as Morse states 'Note that while the exemplar is, by its very nature, situation specific and context bound, the components that are identified as composing the concept (i.e. the attributes) are applicable in any situation in which the concept is used' (Morse 1995 p. 37). The relevant findings from each of these literatures and the generic attributes to emerge from this analysis are given in Table 1 (column A).

Stage two

The analysis of data collected in stage two indicated that nurses always contextualized their interaction with the children in terms of the relationship they felt they had with the child. Nurses talked about an interactive process

Table 1 Concept analysis of control developed iteratively from literature and practice

Column A Concept analysis of control derived from the literature using Walker and Avant's framework	Column B Attributes of the concept of control derived from research into practice experiences
Ability to deal with stress without disintegrating	Sense of agency/choice
'Pause' to deal with information	Constructed from: Developmental framework
Ability to process information	Health framework
Motivation to be in control	Social framework
Ability to perceive social reality	Interactive framework
Degrees of confidence under stress	Paradoxical nature of control
Previous attachments	Professional value system used to interpret behaviour
Sense of mastery in achieving control	Stages to being out of control
Attachment	Stages to the development of relationships
	Micro-analysis of attachment

of 'understanding their feelings' and 'understanding things through the child's eyes' but also in terms of the nurses own feeling which may include 'feeling irritated, stupid and ineffective'.

The data also highlighted the critical role of professional values in shaping assumptions about practice. Nurses recognized that they were in a powerful role as both carers and facilitators of behavioural change and attempted to use their system of values to drive any behaviour change therapeutically, e.g. they discussed 'keeping the child/young person safe, maintaining dignity, providing choice, a degree of autonomy according to developmental level and providing a fair hearing'. Nurses always placed an emphasis on their relationship with the young person and using all interactions to provide a good experience or a learning experience to discover other ways of coping. As one nurse said 'you're always trying to achieve a therapeutic outcome'.

The nurses emphasized continuously the processes involved in developing relationships with the children, in order to facilitate a sense of inner personal control in children. In the initial interview data, however, they did not link their discussions of the development of therapeutic relationships to the attribute of attachment derived from the concept analysis of control (see Table 1, column A). Therefore, they did not make use of theories of attachment, known to them from the professional literature, in their discussions about their nursing role in enabling children and young people to develop an age-appropriate sense of personal control in their lives.

Stage three

Initially the nurses had expressed considerable enthusiasm for the research but during stage three they became overwhelmed by the complexity and the difficulties they encountered in exploring and understanding the concept of control. Some expressed considerable frustration with the limitations of the research in providing pragmatic solutions to very difficult problems. Some of the frustrations and conceptual difficulties are highlighted below.

'Every individual is unique. Frameworks such as the attributes of the concept analysis can't capture this uniqueness and are therefore unhelpful'

Examples included nurses identifying the need to construe personal control in relation to the child's developmental trajectory but, because of the enormous variability in development, there was considerable anxiety that creating a generalized framework would sacrifice what was perceived to be a quintessential value in nursing of treating the child as a unique individual with a unique set of experiences.

'Every interaction is dynamic so don't try to solidify it'

The dynamic nature of control was highlighted in terms of there being 'various stages to loss of control'. Nurses described knowing when to 'move in and try and defuse a situation' when to 'give some space' and when to 'intervene if safety of the child or anybody else is at risk'. The stage of the relationship between the nurse and child was also viewed as critical. It was felt that these stages were highly variable according to the dynamic interaction between sets of individuals, e.g. it was acknowledged that what may work for one person interacting with a child may not work with another. Furthermore, what may work at one point in time will not be the same at another point in time for the same nurse and child.

The inevitability of paradox/the paradoxical nature of control

The paradoxical nature of control was highlighted in terms of children who appear to gain personal control of a situation by appearing to be out of control, e.g. aggression or not eating can allow a child/young person to achieve some sense of personal control even though it may not be perceived to be helpful to their long-term development. There were also examples of how the practice response can be paradoxical, e.g. one nurse described how nurses coming to provide 'support' in a potentially violent situation threatened the young person and provoked further aggression. Another paradox was identified by a nurse who felt that it was important to be 'crystal clear' with the children about limits and boundaries, but on discussion the staff did not feel they could operate with universal limits as they were so linked to personal value systems.

All much too complex

Difficult feelings were identified as emerging inevitably for both the nurse attempting to facilitate personal control as well as the child/young person struggling to maintain/develop personal control. These feelings included fear, anger and frustration. It was felt to be impossible to separate out a facilitation of personal control for the child from that of the nurse because they were mutually interactive and every situation was unique.

For the nurses at this stage the research process appeared to be yet another example of something very interesting but not relevant to practice and there was a real doubt about the progression of the research. However, there was a joint decision in the research group to repeat the process using focus groups where nurses could actually analyse real, current, practice problems instead of looking at the retrospective critical incidents that had formed the content of data collection up to this point.

Stage four

The application of the refined concept analysis to current, real practice problems provided a breakthrough for the nurses, enabling them to see the relevance of the research for practice and facilitating the development of pragmatic management of difficult practice-based situations. This gave rise to the following findings:

The evolving attributes of control derived from the concept analysis highlighted patterns which helped nurses to steer a course through the complexities of practice

In a focus group held in stage four, one of the nurses (nurse A) discussed a young child with whom he was currently working (child 1) who had violent and protracted aggressive outbursts related to a difficulty in dealing with any kind of frustration. The nurse found that giving the child space to calm down at vulnerable times was a relatively effective strategy, instead of attempting verbal counselling. Nurse A was perplexed as to the reasons why sometimes this strategy worked very well, and sometimes did not. Clinical investigations showed that the child had some problems in internal and expressive language, which were slowly improving with intense stimulation.

During the course of the focus group the concept attributes of control, were discussed and applied to child 1. This involved a discussion of the micro-processes involved in the attachment process described by Schaffer (1977), e.g. reading cues, and sequencing interactions into meaningful 'chunks'. On reflecting about his practice with child 1, nurse A identified that the processes associated with attachment potentially provided a more structured and meaningful way/pattern for assessing how his therapeutic relationship was helping the child to develop a sense of personal control. Other concept attributes arising from the concept analysis of control, e.g. the information processing attributes and recognition of the vast amount of information processing involved in the attachment process, and in maintaining personal control, provided nurse A with a much greater appreciation of complexities confronting child 1 which gave rise to his apparently chaotic reactions.

The child's internal language problem provided a potential explanation as to why the reciprocal process of attachment/relationships in the past had been so difficult. Previously, neither he nor his caregivers could predict and respond to each other's cues meaningfully and so the world could not be broken down into meaningful 'chunks' (another attribute of control) for him. Consequently his level of confusion and frustration in everyday life remained critically high and his responses correspondingly chaotic.

In another example, the concept attributes were applied to a child who found it difficult to sustain personal

control. On admission he was unable to tolerate any frustration or simple limit setting without disintegrating into verbal and often physical aggression. He was unable to access adult support which potentially could have helped him resolve these situations.

The evolved concept analysis (Table 1) provided the nurse with a language that enabled her to identify micro-changes in the quality of the child's behaviour 4 weeks later. For example, she was able to describe how the child was starting to seek her out when he was upset. Being able to predict the child's responses made the relationship with the child 'feel more comfortable'. This had a number of therapeutic outcomes. First, it facilitated further development of the reciprocal relationship between the nurse and the child and this provided the child with an opportunity to explore trusting relationships with an adult and to begin to learn how to access adult support. Second, nurses recognized that intuitively they had always known that the ability to predict the responses of a child whose behaviour appeared initially to be chaotic made them feel more comfortable in the relationship. These were important data as they alerted the nurses to use *how comfortable they felt* with the child as critical clinical data which could be acknowledged and shared.

Confronting the paradoxical nature of control was a key insight into understanding practice dilemmas

The group felt that the application of the evolving concept attributes to practice enabled them to make some sense of the perceived dilemmas and paradoxes identified in the previous stages. It was recognized that nurses attempt to view the children as unique and yet seek to establish some general principles. On reflection, it was acknowledged that an understanding of attachment theory facilitated a significant insight for nurses. In particular, it helped them to identify the uniqueness of the child's life experiences in terms of their history of reciprocal experiences of attachment whilst at the same time attachment theory pointed to patterns/frameworks of organized knowledge which could actually help to identify that uniqueness more clearly.

Recognizing the mutuality of feelings aroused simultaneously when both the nurse and the child are challenged to stay in control

The recognition that nurses share the same feelings and difficulties as the children when their own personal control over a situation is challenged arose from the application of the attributes of control to current patients in the unit. In describing their attempts to manage difficult behaviour therapeutically the nurses recognized that both they and the child are subject to the same challenges to

their personal control of the ongoing situation. For instance one nurse commented:

... it's often how they [the children] make you feel and it's often a reflection of how they're feeling themselves... there's a lot of projection.

It was recognized that all of the criteria which we, as practising nurses, were using to assess the children could equally be applied to ourselves. For example, to whom do nurses turn in distress? How difficult is it for nurses to perceive a sense of social reality when they are stressed and may misinterpret cues? The children's behaviour ceased to be viewed as pathological or abnormal but instead was acknowledged as a normal human response to a challenge to one's ability to exercise personal control over a situation. One of the nurses observed that once this situation was acknowledged there was a qualitative difference in the discussion and greater motivation to use the knowledge generated by the research.

The data about nursing practice that emerged from the interviews also identified new insights on the concept of control. For example, that the nurse's feelings and values formed critical clinical data that could be used to monitor the development of personal control in the child. This affective component was not highlighted in the concept analysis undertaken using the Walker and Avant framework. It was instead derived from the iterative process of analysing the nurses' interpretations of their practice and applying the evolving concept attributes to new practice situations. It became apparent therefore that the concept analysis could help nurses explore tacit nursing knowledge, but that explicating nursing's experiential knowledge also modified the defining attributes of the concept. Table 1 (columns A and B) gives the refined concept analysis on completion of the research. Attributes derived from the literature are given in column A, attributes derived from the analysis of interviews and focus groups are given in column B. Together they form the composite concept analysis of control using the modified technique described in this paper.

DISCUSSION

Participatory action research is designed to bring about change, this change can be manifest at a behavioural and/or interpretative level. The experiences of the nurses in this study in living with the evolving research process seemed to mirror the work of Kelly & Conner (1979), described in detail by Lancaster (1982). Kelly and Conner describe an emotional cycle of change on an axis of reflection on practice, against reflection in practice over time. This is given in Figure 1.

Five stages in the emotional cycle are identified. Stage one, 'uninformed optimism' was present at the beginning of the research process. Stage two, 'informed pessimism', was reached at the beginning of the focus groups, when the nurses felt overwhelmed by the data that they had generated and could not see its relevance for their practice. Research did not seem to provide solutions, instead it seemed to obscure them. Stage three, 'hopeful realism', became apparent once the nurses started to apply the analysis of the concept to their current practice. They ceased to be frustrated with the research process and instead became aware of the overwhelming complexities associated with facilitating a sense of personal control in children and young people. These complexities were an integral part of their daily practice and not, as they previously thought, abstractions arising from the research process. Instead these complexities were revealed and labelled by the research process that, combined with a participative methodology, meant the nurses were also forced to confront them.

Stage four, 'informed optimism', was achieved when the application of the evolving concept analysis to current practice problems started to organize the nurse's understanding of them. They were enabled to develop a shared language for describing and categorizing the problems they were dealing with. Stage five, 'rewarding completion', occurred towards the end of the research process when the nurses took the concept analysis and began to develop it into an assessment tool for use in their everyday practice. The results of this development will be

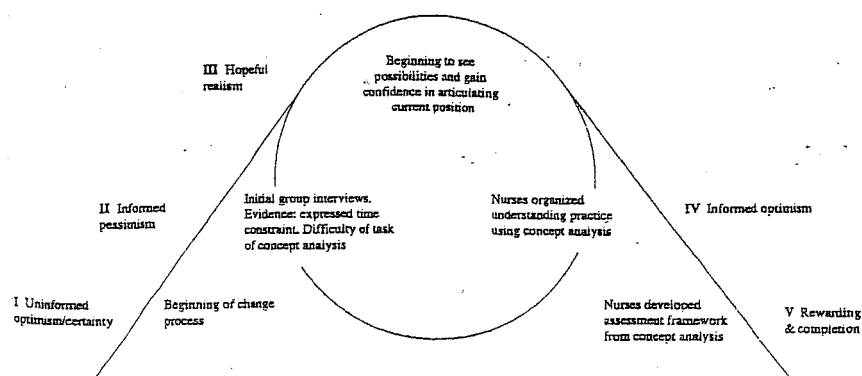


Figure 1 Emotional cycle of change: Kelly & Conner (1979) applied to practitioner care.

published separately with supporting guidance and explanation.

Limitations to the research

Freidson (1971) highlighted the problem of seeking confirmatory evidence in professional practice. Newell (1994) points to the lack of research describing reflection upon professional practice as it affects clients. It is acknowledged that this problem is not overcome by using a reflective process to clarify concepts in nursing. The research appeared to identify that from a nursing perspective, the iterative process of using a concept analysis applied to an inductive analysis of reported practice helped to solve and illuminate some real practice problems. However, the effects of this research on the children and families being cared for by the nurses were not directly explored, consequently Freidson's (1971) concerns still apply.

CONCLUSION

This study set out to investigate whether the findings of the concept analysis combined with qualitative data collection within a framework of participative action research could lead to the development of a holistic knowledge base for nursing practice. Although the concept analysis drew on a diverse range of literature the practice of the nurses was located in the psychotherapeutic milieu found in child and adolescent mental health. Budd (1994), in a discussion of the evolution of psychotherapy, illustrates the role of distance and anonymity in enabling the intensity of the psychotherapeutic relationship to be managed by both participants. The findings from this research reinforce the importance of continuity and immersion in the everyday activities of the child (eating, sleeping, playing) in the provision of nursing care. In managing the complex nature of personal control, the interactions, the paradoxes and the mutuality of the feelings aroused as situations and frustrations actually evolve during everyday life events provides the distinctive, therapeutic context for nursing practice. Because of the continuous daily practice of nursing, nurses are not able to engage in the prepared anonymity and distance of discrete therapy sessions. This presents nurses with a need to develop skills and gain insights into these highly complex spontaneous everyday interactions and to harness these skills and insights in order to make therapeutic progress.

Benner & Wrubel (1989) describe nursing as a means by which the patient can maintain their human identity and integrity. Kitson (1993) develops the concept of caring-as-ethical-position in which the nurse is seen as an autonomous practitioner who uses her/his understanding of the dynamics of the patient situation to make good decisions or correct judgements. The findings reported

here reinforce the descriptions of nursing given by Benner & Wrubel (1989) and by Kitson (1993). They indicate that knowledge generation in nursing will not always result in specialization. This is not to suggest that nursing is unskilled and subservient to other disciplines, rather the knowledge base of nursing was seen to reside in the integration of an existing range of knowledge organized according to the problem to be solved.

Acknowledgement

We would like to thank all the nurse practitioners in The Fleming Nuffield Unit, Newcastle City Health Trust, for their time and creative interest in this research.

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Appendix 4

Information sheet for research being conducted by Susan Croom, Senior Lecturer/Research Fellow

This research is building on research carried out with nurses of the Fleming Nuffield Unit in Newcastle. These nurses are specialist nurses working with children who have a variety of emotional and behavioural problems. Nurses identified that they found the most stressful and challenging situations they encountered were those when they were attempting to help children and young people demonstrate an appropriate level of control in response to everyday stressors e.g. children who reacted very impulsively, aggressively, or destructively when frustrated or stressed. In response to this, a range of skills and knowledge was developed, which nurses found helpful. Parents also seem to be very stressed and challenged by children who do not seem able to develop a sense of control. We would like to share this with you and find out whether you find these skills and knowledge helpful or not, in caring for and managing your child. We would also like to learn from you and find out the kinds of skills and means you find helpful, because you can really help us in developing knowledge.

This will involve asking you for some information and video recording the parent group sessions. The purpose of the video is to enable the researcher to carefully analyse all of the material and discover what skills and knowledge appear to be helpful in a session. She can then plan appropriate sessions for the following week and check out with you that she has closely understood what you were saying.

The video recording can only take place with your permission. You can ask for it to be stopped at any time during any session if you do not feel comfortable and we will respect your wishes.

(Sheet given to parents and also discussed verbally in each cohort)

Appendix 5: Information Sheet and Consent Form

Information sheet for research being conducted by
Susan Croom, Senior Lecturer/Research Fellow

This research is building on research carried out with nurses of the Fleming Nuffield Unit in Newcastle. These nurses are specialist nurses working with children who have a variety of emotional and behavioural problems. Nurses identified that they found the most stressful and challenging situations they encountered were those when they were attempting to help children and young people demonstrate an appropriate level of control in response to everyday stressors e.g. children who reacted very impulsively, aggressively, or destructively when frustrated or stressed. In response to this, a range of skills and knowledge was developed, which nurses found helpful. Parents also seem to be very stressed and challenged by children who do not seem able to develop a sense of control. We would like to share this with you and find out whether you find these skills and knowledge helpful or not, in caring for and managing your child. We would also like to learn from you and find out the kinds of skills and means you find helpful, because you can really help us in developing knowledge.

This will involve asking you for some information and video recording the parent group sessions. The purpose of the video is to enable the researcher to carefully analyse all of the material and discover what skills and knowledge appear to be helpful in a session. She can then plan appropriate sessions for the following week and check out with you that she has closely understood what you were saying.

The video recording can only take place with your permission. You can ask for it to be stopped at any time during any session if you do not feel comfortable and we will respect your wishes.

(Sheet given to parents and also discussed verbally in each cohort)

Parenting Research

Consent Form

I

consent to engaging in the parenting research project with Sue Croom, which is being carried out under NNN trust and the University of Northumbria at Newcastle.

I understand that I can withdraw at any time from the research. I also understand that if I do not give my consent to participate in the research, that this will in no way affect the right of my child or family to future CAMH services or our position on the waiting list.

I understand that the group sessions will be videotaped and that I can ask for taping to be interrupted or stopped at any time.

I understand that all data will be made anonymous, so that my personal details or history cannot be identified in the research report.

Signature

Date

Appendix 6

Example of group session to illustrate how temperament was shared with parents in the group and then analysed and tested out in their practice context.

Introduction to group

Last week we discussed how you felt that at times your children were deliberately winding you up and how this got you mad and frustrated. This week, we're going to look at some of the research on temperament to see if it helps you to understand and manage your child. Remember that we are exploring this together

Information which was shared with parents (this was provided verbally and the parents were also given this written information to take away with them)

Living with children whose behaviour can challenge us

Research and experience shows us that some quite normal children are harder to raise than others because of their 'temperament'. Temperament arises from the kind of traits we inherit such as how easy going we are or whether little things can easily upset us. There is a wide variation in temperament and all aspects of this rich temperamental variation is normal.

The good news is that all of these traits are normal and all of these children can be equally successful, provided that caring adults in their family and later at school understand the way they are and can support them in their individual ways. It is important to remember that the cluster of traits we inherit is a matter of chance and so children, who seem challenging are not 'bad children' and they are not from 'bad parents'. The children often just need understanding and managing in particular ways and the parents need the extra support to provide the extra skills and attention for children who are more challenging than others.

Understanding temperament provides a big step on the way to being able to manage it successfully for both the adult and the child. A range of research has helped us to identify that there are often certain sets of behaviours which go together such as:

- **The high maintenance /challenging child (about 10% of population)**

These children:

Tend to have a more negative mood

Respond with high intensity to situations e.g. 'going off it' if the toy isn't exactly the colour they wanted or they didn't win a game.

Are unpredictable in their sleeping/eating habits

Don't adapt well to any kind of change of activity or routine

Find dealing with new situations difficult (such as first day at school)

Tend to be more persistent and go on and on and on.....

Although these traits can make children more challenging, it can also make them spirited, creative and once they establish a routine, they stick to it, so it is worthwhile helping them to recognise the kinds of situations they find difficult and ways which help them deal with this. They also need to be rewarded for trying and to be helped to see the positive sides of themselves.

- **The easy child (about 40% of the population)**

These children tend to have an overall positive mood

They don't react with great intensity to situations and can generally cope with minor frustrations/disappointments without 'losing it'

They generally enjoy new activities e.g. parties, first day at school

They generally find it easier to change activities e.g. moving from one class to another or one activity to another

- **The slow to warm up child (about 15% of population)**

Tends to withdraw from new activities and needs a lot of coaxing to join in and feel comfortable

Can respond with some difficult behaviour to frustration and can need extra help to deal with it

Can be more negative in mood and needs support to see things positively

Children can also differ widely in their energy and activity levels, how sociable they are, how easily they are distractible/jump from one activity to another and how 'emotional' they are.

All behaviours which can be seen as challenging are also ones that can be seen as strengths e.g. children who are persistent and go on and on and on... are often very loyal and tend to get things done once they set their minds to it.

Children from about 6 can also learn about the kind of temperament they have and learn to deal with it themselves. It is a learning process just like toilet training or learning to read.

Discussion with Parents following information sharing

You may recognise your own temperament in one of these groups. How did family and teachers react to you when you were a child? What helped? What has been helpful in your own past experience in managing your own children?

It can help to communicate to your child that you understand their difficulties e.g. 'I know it's difficult for you to change an activity you've started, so I'll give you a warning now that in five minutes you'll need to come to the table for your meal'

Does this make sense?

Can you think of some ways in which you could let your child know you understand their difficulties and how you may support them?

Challenging /high maintenance children need adults to make more effort to identify and acknowledge the child's positives than the 'easy going child' whose positives are easy to see.

It is more difficult for children who have e.g. a poor attention span, or who does not react positively themselves to get a positive response from adults, especially at school, where they are often asked to concentrate on particular pieces of work for significant periods of time. Understanding and tuning into temperament can make life easier for everybody!

Need for extra support for families and teachers when managing high maintenance/spirited children

It is well recognised in research that it is more difficult to parent/teach a challenging child than an easy going child and parents need more energy, patience and understanding when coping with challenging children. Do you agree? Do you think parents are supported to achieve this?

Practice for next week

What difference do you think it may make if you 'tune into' your child's temperament'

What difference do you think this may make over time e.g. if you continue with this for say 6 months?

What does this teach the child?

What difference do you think it could make for you as a family?

Is it worth the effort?

Is everybody clear about how they will try this out for next week?

How you think you might be able to put some of this into practice at home.

Can you think of two situations you might try this out in as practice for next week?

APPENDIX 7

Lessons learned from Parents so far

Thank you to parents!

Following our discussion on how useful you found information and research on temperament and lessons from your own experience, we have tried to summarise points, which arose from the group discussions.. Just to make sure that we have picked up accurately on the lessons you taught us, can you please help us to go through our summary and check out to make sure it's a true account of your feelings and experiences.

We also want to thank you for the advice you gave us for the future. We have tried to summarise this in points 8 and 9.

1. **Temperament:** Every child has a different temperament, which may be similar to either of their parents.

Depending on their temperament, our children, need to be managed in a way, which matches their needs. It depends on how 'matched' we are as parents, to our child's temperament e.g. a mother may feel that the child is easy 'going' whereas his dad/teacher/gran may find him/her "demanding"

There is genuine difficulty in working out when a child is being naughty and when they need help, because they are temperamentally more challenging and need particular ways of being supported.

2. Recognising how we are feeling as parents can help us to handle situation better e.g. if we feel angry, we may communicate this to children and they may feel it is their fault.

Explanations are really important to children because it can make them feel respected; it helps teach children that it is possible to have feelings of anger; that there are ways of coping with these feelings, which we are modelling and so can help us develop our relationships with children.

We all need support to cope with difficult feelings and we all need to have some time to ourselves, so that we can recharge. There are lots of different ways of doing this. We sometimes need to remind ourselves that everybody in the family has to be taken care of and **that includes mam and dad! We need to feel good about ourselves so that we can help our children feel good about themselves too. We can also have good and bad feelings about people we love (and that includes ourselves and our partners and children)**

3. There is a huge variation in 'normal' behaviour and it can be hurtful/disappointing when we compare (or feel that other people are comparing) our children to others, who seem to be getting on better with rules, being sociable etc.
4. Paying attention to our children.
This can be very hard work and we can't be expected to give total attention to each of our children all day. A "special time" e.g. of 15 minutes a day, where the child knows that's their time is helpful to a child.

Sometimes we can feel as though we are giving attention, when we are not really focusing on what our children are doing e.g. the video clip of the dad, who agreed to play with his daughter, but then read the paper.

Ways of showing child we are paying attention when it is the child's special time:

- a). Looking at them and giving them eye contact
 - b). Commenting on what they're doing e.g. "that's a nice colour"
 - c). Following their lead e.g. if we've decided we want to read to them and they want to play Lego, then joining in with Lego
 - d). Praising their efforts
 - e). Encouraging them
 - f). Being attentive enough to recognise when they need help and when they need to be independent
5. Recognising signs of "frustration" when children help to get out of situation otherwise they will find it all too much and develop a tantrum:

- a) Their facial expression may change
- b) They seem to be more agitated
- c) Their movements change e.g. if building something their movements become more jerky
- d) Being tuned in to what they are capable of so that you gradually let them learn, but not set themselves tasks, which are too hard for themselves
- e) Using gentle tone of voice to avoid getting them anymore agitated
- f) Provide help/distract them to something else

5. If they develop a tantrum:

- a) Paying very close attention (without them being too aware of this) so that we can recognise when "they're too far gone and won't hear anything I say, so I'll have to ignore them or keep them safe but not give lots of attention"
- b) Recognise when they are beginning to calm down and may be able to take on board a visual cue e.g. a sign.
- c) Recognise when it's possible to talk to them and reassure them that they're loved but the behaviour isn't acceptable and why. May need to keep talking to a minimum, when child has limited attention.

6. To help them do as they're told, it can be helpful to:

- a) Give them a warning: in ten minutes, it's tea time....in five minutes it's tea time etc.
- b) Say **when-then** e.g. **when** you've tidied your toys, **then** you can watch teletubbies
- c) Can be really helpful to choose which activities you will use when - then e.g. meal times can be quite difficult for all par4etns and it may not always work to say **when** you eat your meal, **then** you can have your pudding/sweets

7. There is no short cut to observing and studying your child. The pay off is that you can instinctively know what they want. However, with children who are more temperamentally challenging, it is much harder, because they are less predictable. Sharing your understanding of your child and what works for them can be useful for teachers, nurseries and other people, who care for your child.
8. Understanding that children, who are more temperamentally challenging can also be very challenging and stressful to their parents can help us to be more understanding towards their parents, who are trying their best.
9. It can be hard work to notice and praise small steps, which your child is doing well e.g. A struggled to make comments about K when she was being very "good". Sometimes it can take more effort to notice and comment on "good" behaviour, because it doesn't grab our attention the way that "naughty" behaviour can.
10. Professionals need to realise that information can only help so far- it depends on how parents are feeling and how supported they are.
11. Professionals need to understand that parents want their schools to understand their children and their temperament

Appendix 8

Parent's Questionnaire

We would be grateful for your help with these questionnaires. You can help us to work better with parents.

They may also help us to provide the most useful kind of support for you as a parent.

Many thanks.

Questionnaire

1. I feel I understand my child's behaviour

Yes a lot

1

2

3

find it puzzling

4

5

2. I feel in tune/connected with my child

Very much

1

2

3

4

not often

5

3. I feel I can predict my child's moods

Hardly ever

1

2

3

4

most of the time

5

4. I feel wound up/stressed by my child's behaviour

less than once

1-2 times

2-5 times

more than 5 times a

day

a day

5. I enjoy being with my child

most of the
time

often

sometimes

not very
often

find it
difficult

6. I feel supported as a parent

1	2	3	4	5
very well	reasonably	sometimes supported	not very supported	not supported at all

7. I feel isolated as a parent

1	2	3	4	5
not at all			very isolated	

8. I usually feel able to manage my child's behaviour

most of the time	usually	sometimes	don't feel able to cope	not at all
1	2	3	4	5

9. I feel I can discuss how to manage my child's behaviour with my partner/mother/auntie etc.

most of the time	usually	sometimes	never
1	2	3	4

10 I feel my child's nursery/teacher is supportive

most of the time	usually	sometimes	never
1	2	3	4

Appendix 9

1. I feel I understand my child's behaviour

Yes a lot

1

2

3

find it puzzling

4

5

Findings at beginning of cohort		
4	16%	parents found child very puzzling -scored 5
18	72%	of the parents scored 4
3	12%	scored 3
Findings in last session of each cohort		
2	8%	parents scored 4
19	76%	scored 3
4	16%	scored 2

All parents reported a positive change in understanding their child i.e. 100% improvement in understanding their child's behaviour to some extent

2. I feel in tune/connected with my child

Very much

1

2

3

4

not often

5

Findings at beginning of cohort		
1	4%	parents scored 5
5	20%	parents scored 4
18	72%	scored 3
1	4%	scored 2
Findings in last session of each cohort		
21 parents	84%	parents scored 3
4 parents	16%	scored 2

All parents reported feeling more in tune with their children in the last session of the groups compared to the initial session

3. I feel I can predict my child's moods

Hardly ever

1

2

3

most of the time

4

5

Findings at beginning of cohort		
2	8%	parents scored 1
19	76%	parents scored 2
4	16%	parents scored 3
Findings in last session of each cohort		
20	80%	parents scored 3
5	20%	parents scored 4

All of the parents thought it had improved, but those who scored 3 still felt that their child's behaviour was still unpredictable at times.

4. I feel wound up/stressed by my child's behaviour

less than once

1-2 times

2-5 times

more than 5 times a day

Findings at beginning of cohort		
22	88%	felt wound up more than 5 times a day
2	8%	reported 2-5 times per day
1	4%	reported twice
Findings in last session of each cohort		
20	80%	felt it had reduced to 2-5 times
5	20%	said 1-2 times

All parents felt that they were less likely to get wound up by their child's behaviour now although it still happened on a regular basis.

5. I enjoy being with my child

most of the time often sometimes not very often find it difficult

Findings at beginning of cohort		
25	100%	parents said sometimes
Findings in last session of each cohort		
25	100%	parents also said sometimes

However, they all admitted that they had felt too guilty to say in the first session that they did not enjoy being with their child very often because it had become so stressful. Since the group, all felt that their enjoyment had increased but it could still be difficult but said that this was a much more accurate score than they admitted to at the beginning.

6. I feel supported as a parent

1 2 3 4 5
very well reasonably sometimes not very not supported
supported supported at all

Findings at beginning of cohort		
5	20%	did not feel supported at all
17	68%	said not very supported
3	12%	said sometimes
Findings in last session of each cohort		
2	8%	said not very supported
19	76%	felt sometimes
4	16%	felt reasonably well supported

7. I feel isolated as a parent

1 **2** **3** **4** **5**

not at all **very isolated**

Findings at beginning of cohort		
17	68%	<i>felt very isolated and scored 5</i>
8	32%	<i>scored 4</i>
Findings in last session of each cohort		
22	88%	<i>parents said they felt less isolated as a result of being part of the group and scored 3</i>
2	12%	<i>scored 5</i>

All parents agreed it had improved, but that they still felt relatively isolated in the community

8. I usually feel able to manage my child's behaviour

1	2	3	4	5
most of the time	usually	sometimes	don't feel able to cope	not at all

Findings at beginning of cohort		
1	4%	scored 5
2	8%	scored 4
22	88%	scored 3
Findings in last session of each cohort		
22	88%	scored 3
3	12%	scored 2

All parents felt more able to manage but that it was dependent on many factors such as school attitude, their own feelings of stress and not just what we had discussed within the group

9. I feel I can discuss how to manage my child's behaviour with my partner/mother/auntie etc.

1 2 3 4
most of usually sometimes never

Findings at beginning of cohort		
22	88%	scored 3
3	12%	scored 4
Findings in last session of each cohort		
24	96%	scored 3
1	4%	scored 4

Parents felt that the group and access to information has helped them to explain their child's behaviour better but that it required that both they felt up to it and the significant others felt responsive to it.

10. I feel my child's teacher is supportive

most of the time usually sometimes never
1 2 3 4

Findings at beginning of cohort		
18	72%	scored 4
7	28%	scored 3
Findings in last session of each cohort		
5 parents	20%	scored 2
12	48%	scored 3
8	32%	scored 4

All parents reported that they felt more confident about approaching teachers and some felt that the teachers listened, but 8 parents or 32% still felt that although they were able to explain their child's needs better, that school were unable to take this on board.

APPENDIX 10

TABLE OF RISK AND RESILIENCE FACTORS adapted from (PEARCE 1993)

Risk Factors	Resilience Factors
In the Child Genetic influences Low IQ and learning disability Specific developmental delay Communication difficulty Difficult temperament Physical illness especially chronic and/or Neurological	In the Child Being female More intelligent Easy temperament when an infant Secure attachment Positive attitude, problem solving approach Good communication skills Planner, belief in control Humour/religious faith Capacity
In the Family Overt parental conflict Family breakdown Inconsistent or unclear discipline Hostile or rejecting relationships Failure to adapt to a child's changing needs Abuse - physical, sexual or emotional Parental psychiatric illness Parental criminality, alcoholism or personality disorder Death or loss - including loss of friendship	In the Family At least one good parent-child relationship Affection Supervision, authoritative discipline Support for education Supportive marriage
In the Environment Socio-economic disadvantage Homelessness Disaster Discrimination	In the Environment Wider supportive network Good housing High standard of living High school morale and positive attitudes Schools with strong academic and non- academic opportunities Range of sport, leisure opportunities

Pearce, J. (1993) Child Health Surveillance for Psychiatric Disorder: Practical Guidelines. *Archives of Diseases in Childhood*. 69:394-398.

Appendix 11

Protocol for group sessions for parents and facilitators engaging in participative practitioner action research.

1. Introductory session for group
2. Welcome, introductions and ice breaker – fears in a hat exercise.
3. Explanation of research and questionnaires.
4. Generation of ground rules
5. Parents reflect on previous week and consider situations that have gone partially well or not so well. Group decide one or two incidents to focus on.
6. Group reflection on areas that went particularly well or not so well in incident.
7. Generation within group of solutions to problems that have arisen. Generation within group of ways to replicate any areas of good practice (written on flip chart)
8. Parents given access to nursing knowledge and skills and analyse whether any of these are helpful in gaining a greater understanding of the processes involved in caring for children with challenging behaviours. Propositions checked out with parents (*this testing out of propositions takes place over a range of sessions*) and facilitators facilitate discussion in which parents discuss when the proposition applies, when it is relevant or helpful, how it can be refined and any new information arising.

Clinical intervention (takes place over 12-14 weeks)

- i) Access to support group: Use of Ground rules, philosophy of mutual respect and mutual sharing of information.
- ii) Parents given opportunity to identify situations which have been problematic or successful and group discussion on how to solve problem in incident or to explore how to articulate and apply experiential knowledge and good practice represented by incident.
- iii) Facilitators disseminate information related to propositions i.e. attachment information, dealing with reciprocal emotional arousal, ambivalence, information processing, peer interaction, how children with behavioural difficulties can have difficulties accessing help. Parents explore how this nursing knowledge is useful to them or not useful to them in managing the incident under discussion and in providing effective care for their child in their community context. Parents also discuss any difficulties they feel they may encounter in applying the knowledge and skills. As knowledge and skills evolve through group, any refinements or new knowledge are disseminated to subsequent groups of parents.

iv) Parents given access to evidence base on parenting programme as exemplified by Cunningham et al (1996) below. In subsequent groups to additional information that relates to previous incidents under discussion.

1. Introduction, information about group and setting of aims and ground rules.
2. Helping parents to pay attention to their children and communicate on positive aspects of their behaviour.
3. Planned ignoring of behaviours to avoid constant confrontations.
5. Setting limits
6. Use of 'when/then warnings e.g. when you've tidied your toys, then you can watch TV.
7. Giving clear instructions about limits
8. Planning ahead so that children know in advance what is expected of them in situations
9. Application of behavioral principles: use of positive reinforcements and charts
10. Use of 'Time out' i.e. withdrawing attention completely from child
11. Problem solving

Practice research. Testing out of propositions derived from previous study upon which this builds using action research cycles:

Discussion of incident, how group understands incident, how group subsequently understands incident when they are provided with access to additional information (underpinning sub propositions in box 1)

Exploration of what parents find useful about solutions arising from their experiential discussion or through access to the additional knowledge and decision making about how this can be applied to their everyday lives.

Identification of action/solutions and how they can be implemented in home setting

Transcriptions and analysis of group discussion. Identify additional literature related to new emerging themes

Refine propositions and theory emerging from analysis

Propositions to be inductively explored

- 1) That the nursing knowledge and skills derived from the nursing project (Croom 1996) will be useful to parents in their 24 hour context in the community, when caring for their child with behavioural problems.**
- (2) That the parents can refine and develop the nursing knowledge and skills (Croom 1996) and so add to a cumulative body of practice knowledge and skills related to the 24-hour management of children with behavioural problems.**
- (3) That the parents can increase their capacity to respond effectively to their children with behaviour problems by gaining access to a diverse body of knowledge and by being participant researchers in the knowledge production process.**
- (4) That the service planners and providers can utilise parental knowledge, expertise and insight into caring for children with behavioural problems throughout their 24 hour life span in order to increase the systemic capacity to respond more appropriately and effectively to the needs of these children**

Sub propositions to be inductively explored (derived from the research with the nurses), which are inductively analysed and modified with the parents to test out proposition 1 in box 1.	
1.1	Developing a reciprocal attachment relationship, in which the child and their significant carer(s) become “in tune” with each other is essential to the management of children with emotional and behavioural problems
1.2	In order for carers to manage situations where their child is emotionally aroused/becoming out of control, the carers first need to manage the reciprocal arousal they feel themselves
1.3	There is a need to recognise that carers have feelings of ambivalence towards those they care for
1.4	Acknowledging and managing ambivalence is a healthy component of close relationships
1.5	It is essential to understand and acknowledge that children who exhibit behavioural problems often have difficulties in expressing and also in appropriately seeking help when they are frustrated or distressed.
1.6	<p>Understanding how to help a child to “process information” in a way which enables he /she meet his/her social, developmental and emotional goals is essential. Knowledge and skills on various stages in information processing are useful to carers in managing children. These include:</p> <ul style="list-style-type: none"> • Helping a child to “create a pause” in order to “stop and think” • Helping a child to selectively attend to social, emotional and situational cues in a range of situations • Helping a child to interpret these cues in ways, which are effective to them in meeting their social, emotional and developmental goals. • Helping a child manage the emotional arousal which may arise from the interpretation • Helping the child to be able to formulate the goal/ outcome, which they wish to achieve from a given situation, recall how they have previously coped in that kind of situation, think of alternative ways of coping and select a strategy which can help them achieve their chosen goal • Helping a child to feel confident about being able to implement the chosen strategies to achieve their goal • Helping a child to evaluate their performance and so learn from one situation to another.
1.7	Knowledge and skills on peer relationships which nurses found useful in an in-patient setting such as high levels of supervision and teaching social skills will be useful for parents managing their children in their family setting within the community.

10. Parents discuss how access to this knowledge and research process is useful to them and identify when it is not helpful. Parents generate solutions which can help them to solve problems emerging from analysis of incident, access to above information and research discussion and how this related to their own context. (Written on flip chart)

11. Parents discuss how they can apply solution to their context and agree to test this out before following group session. (Written on Flip Chart)
12. Group ending. Thanks for participation and promote motivation for returning following week.
13. Facilitators discuss group, analyse flip charts and write field notes.
14. Analysis of transcription by researcher for:
 - Evidence which support relevance of nursing knowledge and skills to parent
 - Evidence which refutes relevance of knowledge and skills.
 - (If this is a subsequent group) Additional knowledge which was useful to parents from further literature search
 - Iterative refinement of knowledge and skills
 - New emerging themes
 - Any assumptions that could be oppressive to parents.
 - Researcher compares any new themes emerging to research to identify if any further information/literature can be shared with the parents at following session.
15. Check out themes with other facilitators prior to next group. Plan for next group session.

Following group Session

16. Parents report back on how helpful the solutions generate in previous session have been to them in the previous week.
17. Facilitators feed back the themes arising from analysis of the transcription and field notes and check them out with parents.
18. Facilitators feed back on any additional literature, which has arisen from comparison of themes in transcription with literature.
19. Group agree on knowledge and skills that have been helpful so far, discuss how new literature can be tested out and explore the impact of any oppressive assumptions and how to change them. *Written on Flip Chart*
20. Process begins again with a new incident from parent.

Process repeated.

21. This process continues iteratively until the parents have had the opportunity to access all of the nursing knowledge and skills and the knowledge arising from Cunningham et al's evidence based parenting programme and to explore any new literature or learning arising from previous cohorts and have been given the opportunity to critique this information, to test it out in practice and feed back their findings to the group.
22. Ending group session:
 - Questionnaire
 - Discussion of what researchers have learned
 - Discussion of what parents have learned
 - Discussion on how parents can continue to implement and to develop learning following group in order to continue to develop their resilience.
23. Evolving knowledge and skills synthesised into practice framework, which can be iteratively tested out with further cohorts and also in future practice research.